

Version 2.0 November 1999



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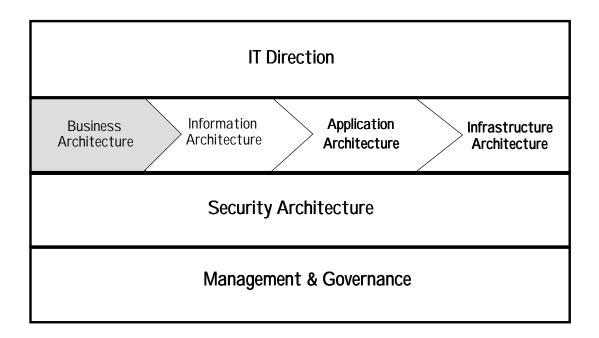
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Volume 2 Business Architecture

2.1 Introduction

This volume describes the Business Architecture component of the HCFA Information Technology Architecture (ITA). Exhibit 2-1 below shows the relationship of the Business Architecture component to the overall ITA.

EXHIBIT 2-1. HCFA'S ITA COMPONENTS



An enterprise-wide ITA is designed to align an enterprise's IT systems and infrastructure with its business needs. The Business Architecture is an essential component of an ITA, as it provides a knowledge base of what the business is and sets the stage for identifying what information is used to conduct business. It supports the needs of the business rather than the needs of specific individuals within that business. The Business Architecture defines what, where, by whom, and why the business is performed. It provides a business-driven approach for determining the proper information, applications, and technology required by the enterprise. By understanding the business of the enterprise, we can better define the IT needed to achieve the enterprise objectives.

A well-defined Business Architecture is vital to both the ITA and the enterprise as a whole. It

can serve as a stimulus for developing detailed business plans and business contingency plans for the enterprise. It can be used in performing impact analyses when adapting to changing business needs, and it can provide a tool for establishing a structured approach to organizational planning. The more you know about an enterprise's business functions and IT needs, the better you can optimize the system, adapt to change, and accomplish enterprise objectives.

The remainder of this volume is organized as follows:

- Section 2.2 identifies HCFA's business direction by presenting the Agency's mission, vision, goals, objectives, and business drivers. It also defines the context (information exchanges between HCFA and those with whom we do business) in which we achieve our mission, vision, and goals through our objectives.
- Section 2.3 defines the Agency's functional areas and functions, as well as high-level processes chosen in specific business areas based on Agency priorities. This section also maps the Agency objectives to the functional areas and functions that we perform.
- Section 2.4 presents HCFA's organizational structure and identifies which organizations perform each function. It also describes where the functions are performed.
- Section 2.5 provides a brief discussion of the Business Architecture Modeling Policy Framework.
- Section 2.6 describes the relationship of the Business Architecture to the other components of the ITA.
- Section 2.7 contains a feedback form with which readers can provide comments and feedback on the Business Architecture.

An electronic version of this volume can be found on the HCFA ITA Intranet site at http://hcfanet.hcfa.gov/hpages/ois/ita.

2.2 HCFA Strategic Business Direction

This section describes HCFA's mission, vision, goals, and objectives as presented in the HCFA Strategic Plan¹, as well as the business drivers that influence HCFA's strategic direction. This section also provides a contextual view of HCFA and its business partners, along with the information exchanges that are required to conduct HCFA-related business. Together, these elements provide the objectives for HCFA's business and help determine the business functions necessary to achieve those objectives.

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¹ HCFA, Health Care Financing Administration Strategic Plan, September 1998 (Publication No. HCFA-02135)

2.2.1 Mission and Vision Statements

HCFA's mission statement concisely explains what we are about and depicts what we aspire to do now and in the future.

The HCFA mission and vision follow:

HCFA Mission: "We assure health care security for beneficiaries."

In the context of HCFA's mission statement, health care security means:

- Access to quality health care services that are affordable to beneficiaries;
- Protection of the rights and dignity of beneficiaries; and
- Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

HCFA Vision: "In the stewardship of our programs, we lead the Nation's health care system toward improved health for all."

This vision statement reflects HCFA's commitment that:

- In cooperation with States and other partners, we will strive to ensure the best possible health outcomes for program beneficiaries;
- We will purchase health care for our beneficiaries that represents best-value, highquality care at the best possible price; and
- We will use our market presence as the nation's largest purchaser of health care to promote continuous improvement in both quality and value throughout the health care system.

In the development of HCFA's mission and vision, one of the elements considered was the effect of the numerous market influences on the enterprise. The next section identifies those influences as business drivers that affect how HCFA conducts business.

2.2.2 Strategic Plan Goals and Objectives

HCFA's strategic goals form the basis for its strategic plan. These goals represent the understanding of HCFA's statutory responsibilities and provide a broader sense of purpose and direction as seen through the perspective of HCFA. In order to achieve its strategic goals, the Agency developed a set of more specific objectives that support those goals.

2.2.2.1 Strategic Plan Goals (SPGs)

SPGs are broadly defined statements of what the enterprise would like to accomplish within the planning horizon, which is generally 3-5 years. HCFA's SPGs are presented in Exhibit 2-2.²

EXHIBIT 2-2. HCFA STRATEGIC PLAN GOALS (SPGS)

| Goal | Statement |
|-------|---|
| SPG-1 | Protect and improve beneficiary health and satisfaction |
| SPG-2 | Purchase the best-value health care for beneficiaries |
| SPG-3 | Promote the fiscal integrity of HCFA programs |
| SPG-4 | Provide leadership in the broader public interest to improve health |
| SPG-5 | Promote beneficiary and public understanding of HCFA and its programs |
| SPG-6 | Foster excellence in the design and administration of HCFA's programs |

2.2.2.2 Strategic Objectives

While SPGs may be viewed as high-level statements of what we are going to accomplish, strategic objectives provide high-level statements of how we are going to accomplish it. Many of the strategic objectives support multiple SPGs. The strategic objectives are grouped into the broad functional categories of Customer Services, Quality of Care, and Program Administration. Exhibit 2-3 lists the strategic objectives grouped by broad functional categories as identified in the HCFA Strategic Plan.³

2-4

² HCFA, *Health Care Financing Administration Strategic Plan,* September 1998 (Publication No. HCFA-02135)

³ Ibid.

EXHIBIT 2-3. HCFA STRATEGIC OBJECTIVES

| Customer Services (CS) | | | | |
|------------------------|--|--|--|--|
| Objective CS-1 | Improve beneficiary satisfaction with programs, services, and care | | | |
| Objective CS-2 | Enhance beneficiary program protections | | | |
| Objective CS-3 | Increase the usefulness of communications with beneficiaries | | | |
| Objective CS-4 | Increase the usefulness of communications with constituents, partners, and stakeholders | | | |
| Objective CS-5 | Ensure that programs and services respond to the health care needs of beneficiaries | | | |
| | Quality of Care (QC) | | | |
| Objective QC-1 | Improve health outcomes | | | |
| Objective QC-2 | Improve access to services for underserved and vulnerable beneficiary populations | | | |
| Objective QC-3 | Protect beneficiaries from substandard care | | | |
| | Program Administration (PA) | | | |
| Objective PA-1 | Build a high-quality, customer-focused team | | | |
| Objective PA-2 | Enhance program safeguards | | | |
| Objective PA-3 | Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds | | | |
| Objective PA-4 | Increase public knowledge of the financing and delivery of health care | | | |
| Objective PA-5 | Improve HCFA's management of information systems/technology | | | |

A pictorial representation of the relationships among the various strategic planning components (mission and vision statements, strategic plan goals, objective categories, and strategic objectives) is shown in Exhibit 2-4.

Mission "We assure health care security for beneficiaries." Vision "In the stewardship of our programs, we lead the Nation's health care system toward improved health for all." Goal Goal Goal Goal Goal Goal Promote Provide leadership Protect & improve Purchase the best-Promote the fiscal Foster excellence beneficiary & in the broader beneficiary health value health care integrity of HCFA in the design & public underpublic interest to administration of & satisfaction for beneficiaries programs standing of HCFA improve health HCFA's programs & its programs Program Customer **Quality of Care** Administration Services **Objectives Objectives Objectives** CS-1 CS-2 QC-2 QC-1 PA-1 PA-2 Improve beneficiary Improve access to Enhance Improve health Build a high-quality Enhance program services for undercustomer-focused satisfaction with beneficiary outcomes safeguards served and vulnerprograms, services, program team able beneficiary and care protections populations PA-3 PA-4 CS-3 CS-4 QC-3 Maintain & improve Increase the HCFA's position as Increase public Increase the usefulness of Protect beneficicommunications a prudent program knowledge of the usefulness of aries from subadministrator & an financing & delivery communications with constituents, standard care accountable stewof health care with beneficiaries partners, and ard of public funds stakeholders CS-5 PA-5 Improve HCFA's Ensure that programs & services management of respond to the information health care needs systems/ of beneficiaries

EXHIBIT 2-4. HCFA STRATEGIC PLAN GOALS AND OBJECTIVES

Now that we have considered the components of the HCFA Strategic Plan, we must consider those key factors, or business drivers, that have had an impact upon the formulation and implementation of this plan.

technology

2.2.3 Business Drivers

For any organization or business, there exist certain factors, i.e., *business drivers*, that influence the organization's decisions about its direction and priorities. Some drivers are external factors affecting the business, such as customer needs and preferences, industry trends, and technology, while others are internal, such as leadership changes, cash flow considerations, and internal funding priorities.

Business drivers affect business decisions about which operations will continue, which will change, and which will be discontinued. They ultimately affect decisions related to the use of information technology to support the business.

HCFA is influenced by many external and internal drivers that affect decisions about the Agency's direction and priorities. In recent years, government and the health care industry have been undergoing rapid changes as a result of increased passage of new legislation, more initiatives for less government spending, more medical technology breakthroughs, more information technology breakthroughs, etc.

By being sensitive to its business drivers, HCFA is positioning itself to allow for a rapid and agile response to changes in the business and health care environments. The drivers are affecting many areas of program operations, including the delivery of health care services to beneficiaries and the effectiveness of the Agency's many relationships with health care providers, contractors, insurance carriers, State agencies, and other partners. The business drivers are strongly influencing the success or failure of initiatives involving these program areas.

HCFA management was careful to take business drivers into account while developing the Agency's Strategic Plan, which was released December 17, 1998. The plan articulates how the Agency intends to accomplish its mission and achieve its vision through its Strategic Plan goals and strategic objectives. The plan builds upon our earlier efforts and reflects the new responsibilities given to the Agency under the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997.

Exhibit 2-5 illustrates the relationships between the business drivers and the components of the Agency's Strategic Plan. It also illustrates how the plan influences HCFA's program initiatives and the Agency's IT strategy and IT initiatives (what we will accomplish through IT and how it will be accomplished, respectively).

HCFA MISSION HCFA VISION BUSINESS HCFA DRIVERS Strategic Plan **HCFA GOALS** influence HCFA **STRATEGIC OBJECTIVES** influences **HCFA INITIATIVES BUSINESS ARCHITECTURE OBJECTIVES** guides IT **INITIATIVES**

EXHIBIT 2-5. HCFA'S STRATEGIC PLANNING COMPONENTS

In the HCFA Strategic Plan, external business drivers are referred to as *key external factors*. They are:

- Being a "Public" Purchaser of Health Care
- HCFA's Reliance upon its Partners in Conducting Business
- Millennium Compliance Challenges
- New Statutory Mandates
- Program Integrity
- Changes In Health Care Delivery
- Medical Technology Advances
- Demographic Changes of its Customers.

Also, the Strategic Plan makes frequent reference to internal business drivers. In the Business Architecture, we refer to these internal business drivers as *key internal factors*, which are:

- Increasing Focus on Beneficiaries
- Strengthening HCFA Management

Exhibit 2-6 identifies HCFA's business drivers, both the key external factors and the key internal factors. For each factor, the exhibit identifies the implication, or consequence, of the driver to the Agency. These are identified in the first two columns of the exhibit.

The business drivers and the implications to the Agency, in turn, influence both HCFA's strategic objectives and the Agency's IT objectives. These objectives are identified in the last two columns of Exhibit 2-6.

As additional prospective business drivers are identified, they are subject to ongoing analysis to determine their impact on both the HCFA business strategy and information technology usage.

EXHIBIT 2-6. HCFA'S BUSINESS DRIVERS AND OBJECTIVES

| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|--|---|--|---|
| Key External Factors PUBLIC PURCHASER HCFA has established a business goal to purchase the best-value health care for beneficiaries. | HCFA's interdependence with a changing health care environment presents both challenges and opportunities with respect to the achievement of the Agency's strategic goals and objectives. | CS-5: Ensure that programs and services respond to the health care needs of beneficiaries. PA-2: Enhance program safeguards. PA-3: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. | ITO-1: Meaningful information is readily accessible to HCFA's beneficiaries, partners, and stakeholders. ITO-2: The security of those HCFA information assets that support business processes is ensured. ITO-3: IT resources are carefully planned and deployed to maintain continuity of service. ITO-4: IT support to HCFA's business processes is efficient. ITO-5: IT resources are maneuverable (flexible and adaptable). ITO-6: IT is effectively applied to HCFA's business needs. ITO-7: IT is effectively applied to support program integrity. ITO-8: IT core competencies of HCFA staff are targeted and strengthened. |

| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|---|--|--|---|
| PARTNERSHIPS HCFA accomplishes its mission by working with and through a complex network of organizations, which includes other Federal agencies, States, Tribes, providers, etc. | The Agency's success is dependent on the effective interoperability of a wide-ranging network of diverse organizations. | CS-4: Increase the usefulness of communications with constituents, partners, and stakeholders. PA-1: Build a high-quality, customerfocused team. | ITO-1, ITO-5, ITO-6, and ITO-8, as itemized for the <i>Public Purchaser</i> driver. |
| MILLENNIUM COMPLIANCE HCFA and its contractors employ a variety of computer hardware and software systems to support the Agency's mission of providing health care for its beneficiaries. These systems need to be able to process correctly before and after December 31, 1999, in order to avoid disruptions in program payments and to sustain key information reporting requirements. | HCFA's response to preparing for the century date change has consumed significant Agency and contractor resources and funding. This strain on resources has created a backlog of information technology efforts to support program operations. | PA-5: Improve HCFA's management of information systems/ technology. | ITO-1 through ITO-8, as itemized for the <i>Public Purchaser</i> driver. |
| NEW STATUTORY MANDATES Enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Balanced Budget Act (BBA) of 1997 has made significant changes to the statutory framework within which HCFA operates. | The Agency needs to focus its resources on immediate implementation efforts in order to deploy a wide range of new program activities in a relatively short time. | CS-2: Enhance beneficiary program protections. CS-3: Increase the usefulness of communications with beneficiaries. CS-4: Increase the usefulness of communications with constituents, partners, and stakeholders. QC-1: Improve health outcomes. QC-2: Improve access to services for underserved and vulnerable | ITO-1 through ITO-8, as itemized for the <i>Public Purchaser</i> driver. |

| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|--|---|---|--|
| Enactment of the Clinger-Cohen Act of 1996 requires the HCFA IT organization to better support the Agency's mission and objectives, and to improve program performance through the appropriate use of information technology. | HCFA needs to ensure that its business direction and priorities are the basis for aligning information technology initiatives and for making IT investment priority decisions. | beneficiary populations. QC-3: Protect beneficiaries from substandard care. PA-2: Enhance program safeguards. PA-5: Improve HCFA's management of information systems/ technology. | |
| PROGRAM INTEGRITY The size and scope of HCFA's programs necessitate an emphasis on the prevention and detection of waste, fraud, and abuse. | HCFA must take effective measures to prevent improper or fraudulent claims, and to ensure that the pursuit of efficiency and cost-effectiveness does not compromise access or health care quality, while ensuring program funding is appropriately spent. | CS-2: Enhance beneficiary program protections. QC-3: Protect beneficiaries from substandard care. PA-2: Enhance program safeguards. | ITO-1 through ITO-3 and ITO-5 through ITO-8, as itemized for the <i>Public Purchaser</i> driver. |
| CHANGES IN HEALTH CARE DELIVERY The growth of managed care delivery arrangements in the 1990's has been significant. More than 100 million people are now enrolled in some form of managed care. Uninsured and underinsured populations are growing due to the rising cost of employer-based health insurance benefit plans. | HCFA must better understand the health care needs of its beneficiaries. The Agency must develop effective and up-to-date purchasing strategies for both fee-for-service and managed care environments. | QC-1: Improve health outcomes. QC-2: Improve access to services for underserved and vulnerable beneficiary populations. PA-4: Increase public knowledge of the financing and delivery of health care. | ITO-1, ITO-5, ITO-6, and ITO-8, as itemized for the <i>Public Purchaser</i> driver. |

| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|--|---|--|--|
| TECHNOLOGICAL ADVANCES Medical technology is evolving and unfolding more rapidly than ever; it is changing the nature and delivery of health care. Technological advances and supporting procedures are one of the primary reasons that health care costs have risen faster than the consumer price index. | HCFA needs to ensure that beneficiaries have access to new technologies as supported by authoritative scientific evidence, and that new technologies and procedures covered by Medicare are reasonable and necessary. | CS-5: Ensure that programs and services respond to the health care needs of beneficiaries. QC-1: Improve health outcomes. | ITO-1, ITO-4 through ITO-6, and ITO-8, as itemized for the <i>Public Purchaser</i> driver. |
| DEMOGRAPHIC CHANGES Steady improvement in life expectancy is expected to result in major increases in the number of older persons relative to those of working age. A substantial proportion of the future aged population will require medical care. Payroll tax revenues will not keep pace with expected Medicare expenditures. | HCFA needs to identify problems that threaten its fiscal integrity and carry out actions to address long-term financial challenges. | PA-3: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. | ITO-1 and ITO-4 through ITO-7, as itemized for the <i>Public Purchaser</i> driver. |

| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|--|---|--|--|
| Key Internal Factors | | | |
| FOCUS ON BENEFICIARIES Emphasis on accountability/ stewardship and a renewed focus on the "customer" due to varied initiatives, such as those related to the HCFA Strategic Plan begun in 1994, the Government Performance and Results Act, and other DHHS- and government-wide initiatives. | HCFA has renewed and needs to sustain its commitment to beneficiaries as the ultimate focus of all Agency activities, expenditures, and policies. | CS-1: Improve beneficiary satisfaction with programs, services, and care. CS-2: Enhance beneficiary program protections. CS-3: Increase the usefulness of communications with beneficiaries. CS-5: Ensure that programs and services respond to the health care needs of beneficiaries. QC-1: Improve health outcomes. QC-2: Improve access to services for underserved and vulnerable beneficiary populations. QC-3: Protect beneficiaries from substandard care. | ITO-1, ITO-4 through ITO-6, and ITO-8, as itemized for the <i>Public Purchaser</i> driver. |

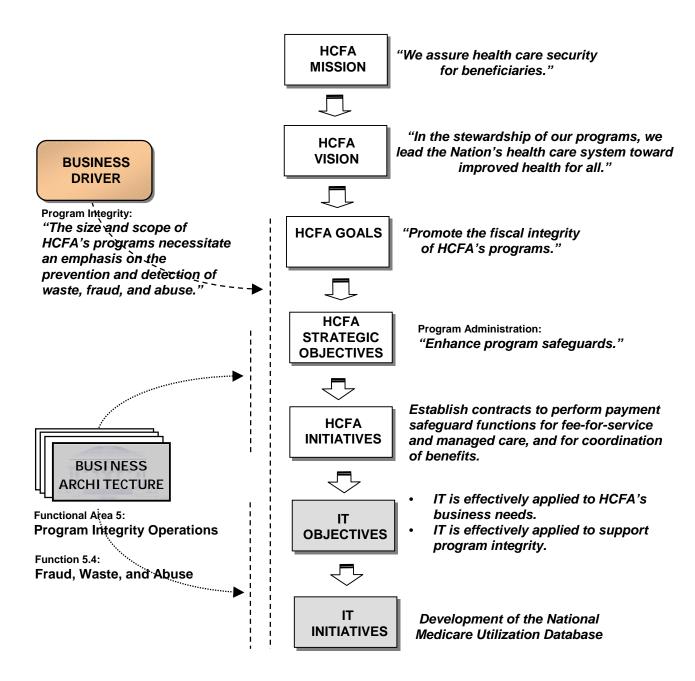
| Business Drivers | Implication to HCFA | HCFA Strategic Objectives (Response to Business Drivers) | IT Objectives (IT Response to HCFA Objectives) |
|---|--|--|---|
| HCFA MANAGEMENT Since HCFA's establishment in 1977, the Agency's statutory responsibilities have grown beyond the administration of Medicare and Medicaid to include responsibility for Federal oversight of clinical laboratories, Medigap insurance, health insurance regulation for individuals and small groups, and the expansion of health insurance coverage to low-income children. | HCFA must continue to perform an array of critical functions necessary for program administration within tightening budget constraints. The Agency needs to examine the possibility of improvement in structuring work more efficiently, maintaining a more effective and efficient organizational structure, providing for more effective partnering, and continually upgrading critical management and operational skills. | CS-4: Increase the usefulness of communications with constituents, partners, and stakeholders. PA-1: Build a high-quality, customerfocused team. PA-2: Enhance program safeguards. PA-3: Maintain and improve HCFA's position as a prudent program administrator and an accountable steward of public funds. PA-4: Increase public knowledge of the financing and delivery of health care. PA-5: Improve HCFA's management of information systems/technology. | ITO-1 through ITO-8. |

Exhibit 2-7 is a tangible illustration of the alignment of the Agency's business strategy with the execution of the appropriate information technology initiatives, all in response to a business driver. More specifically, the exhibit shows that in response to the business driver that emphasizes "prevention and detection of waste, fraud, and abuse," HCFA adopted a strategy to "enhance program safeguards" through the establishment of contracts to perform payment safeguard functions and to coordinate benefits. Proposed funding for these contracts has been included in HCFA's FY2001 budget submission to DHHS. To meet the needs of this contracting initiative, as well as related initiatives, the Agency adopted the following information technology objectives:

- IT is effectively applied to HCFA's business needs.
- IT is effectively applied to support program integrity.

From an information technology perspective, HCFA is currently developing the National Medicare Utilization Database as part of an effort to meet Agency business needs related to reducing waste, fraud, and abuse.

EXHIBIT 2-7. EXAMPLE OF A BUSINESS DRIVER INFLUENCING HCFA STRATEGY AND IT INITIATIVES



In summary, HCFA is being sensitive to its business drivers, both external and internal. The Agency is positioning itself to be more adaptable to change.

From an information technology perspective, this means that we must, for example, provide better access to more meaningful data, increase the efficiency and effectiveness of information technology support, more carefully manage our information technology resources, and increase the adaptability of our computer applications.

This adaptability is described in the *IT Vision*, *IT Objectives*, and *IT Guiding Principles* sections of Volume 1. These sections further describe the direction that will allow HCFA to meet the information technology challenges of the future.

We have now viewed HCFA from a strategic business perspective. This perspective is a critical input to the enterprise-wide ITA effort. To understand the context in which the business operates in implementing its strategic objectives, and to develop an enterprise-wide ITA, we must identify the business partners and the exchange of information required to accomplish the Agency's mission.

2.2.4 Business Context Diagram

The Business Context Diagram presented in Exhibit 2-8 is a logical representation of the HCFA business enterprise. This diagram shows the enterprise as a single entity and identifies the information that is exchanged by HCFA and its external entities (persons, places, things, or events that HCFA encounters in the course of doing business). The center of the diagram represents the HCFA enterprise functions, whether they are performed by HCFA or its agents (e.g., intermediaries, carriers, State agencies, Peer Review Organizations). These agents are represented by the shaded boxes.

The Business Context Diagram establishes the scope of the enterprise architecture effort from a business perspective, identifies external entities with which the enterprise interacts or interfaces, and provides an understanding of the enterprise's interactions that must be accommodated by the ITA.

The entities identified in the Business Context Diagram are described in Exhibit 2-9.

Accrediting Organizations Diagnosis Procedure Credit, Letters Policy Procedures Entitle ant Funds pended, Loc Зох, Beneficiaries Premiu Payment Info Provider & Account Information Care ation Policy: Procedures sight is policy: Procedures info...

Budget Funding Procedures info...

Budget Funding Procedures info...

Provider Funding Procedures info...

Transfer Payments Claims Info... Medicare Operations Contractors Regulations, Policy, Funding, Info., Progress Reports, Audits Dept. of Health and Human Services Insurance Trading Agreements, Claim **Partners** Payment Information Payment/Invoice, Oversight,

Payment/Invoice, Oversight,

Products, Services "Sanitized" Data, **Data Requests** Encounter Data, Enrollment Non-Program Coordination, Encounter Data, Enrolments

Encounter Data Payments

Capitated Payments

Data Oversight, Policy destes Responses frostation Mortalications information Reports Information Contractors/ Vendors Information, Reports Health Standards,
Program Information,
Provider/Supplier Certification,
Policies, Procedures,
Reports, Informa ion Managed Care Other Federal Organizations Agencies (e.g., IRS, GSA, HUD, OPM) **Utilization Data** Entitlement Congress **General Public States Labor Unions** Organizations (e.g., SSA, RRB, OPM) Shaded external entities are those that perform functions for HCFA to support our mission and that are under HCFA control for performing these functions. Those external entities that are not shaded merely exchange information with HCFA, but do not perform mission-related functions.

EXHIBIT 2-8. BUSINESS CONTEXT DIAGRAM

EXHIBIT 2-9. HCFA CONTEXT DIAGRAM ENTITIES

| Name | Description |
|---|---|
| HCFA | Functions performed by HCFA and/or its agents to support the Agency's mission, including claims and encounter data processing, health care quality activities, analysis by specialty contractors, and other program-related activities; the transfer of information for performing these operations; and the necessary administrative, operational, and policy-making activities. |
| Accrediting Organizations | Organizations that evaluate health care facilities, including those participating in HCFA programs, whose accreditation HCFA accepts in lieu of HCFA certification. |
| Quality Organizations (e.g., PRO, ESRD Network) | Organizations that work to ensure the quality of medical care for beneficiaries of HCFA-administered programs. Peer Review Organizations (PROs) are groups of medical and surgical professionals who contract with HCFA to review providers of health services and related items to ensure that services to beneficiaries are reasonable and medically necessary, of a professionally recognized standard, and provided in the most economical setting. End Stage Renal Disease (ESRD) Network Organizations are contractors to HCFA representing geographic groups of ESRD providers and beneficiaries. They include medical review boards and ensure quality of care for ESRD beneficiaries. Also included are organizations that ensure quality of care provided by managed care organizations. |
| Banks | Any commercial bank with which HCFA and the Department of Treasury have established a letter of credit for a contractor, or any commercial bank that acts as a lock-box contractor. |
| Standards Organizations | National and international organizations chartered to develop and promulgate technological standards, e.g., ANSI, IEEE, ISO. |
| Medical Associations | Organizations such as the American Medical Association, American Hospital Association, etc., that represent HCFA's professional partners. |
| Providers | Individuals or organizations which are approved by HCFA or its agents to render health care services, equipment, or supplies. |

| Name | Description |
|---|---|
| Medicare Operations Contractors | Organizations, public or private, that have entered into agreements with HCFA to process claims/encounter data or support claims/encounter data processing. These include fiscal intermediaries, specialty contractors, statistical analysis contractors (SACs), program safeguard contractors (PSCs), coordination of benefits contractors (COBs), payment safeguard contractors, Part A, Part B, CWF, DMERC, and RHHI processing, and the print/mail premium collection contractor. |
| Insurance Trading Partners | Insurance companies with whom HCFA exchanges information to ensure that all involved parties make correct payments on beneficiary claims. |
| Non-Program Contractors/Vendors | Individuals or groups under contract to provide various goods and services not directly related to the operation of HCFA-administered programs. |
| Other Federal Agencies (e.g., IRS, GSA, HUD, OPM) | Any Federal agency that receives information from or provides information to HCFA. |
| Entitlement Organizations (e.g., SSA, RRB, OPM) | Government organizations (Social Security Administration, Railroad Retirement Board, Office of Personnel Management) that determine a person's entitlement for Medicare coverage. |
| Labor Unions | An officially recognized organization with the purpose of representing appropriate categories of employees for matters requiring labor and management bargaining or negotiation. |
| States | All the States of the United States, plus Guam, the Northern Mariana Islands, American Samoa, Puerto Rico, the Virgin Islands, and Washington, D.C. |
| General Public | Any person or group (including employee and beneficiary organizations) not representing a government agency at any level. Corporations are included. Persons enrolled in HCFA-administered programs are excluded when their interest is directly related to their benefit status. |
| Congress | The Congress of the United States as created by Article I, Section 1, of the Constitution, and adopted by the Constitutional Convention on September 17, 1787. The Congress is the source of legislation, funding authorities, and oversight of Federal agencies such as HCFA. |

| Name | Description |
|---|--|
| Managed Care Organizations | Organizations that provide health services to enrolled members, either directly or by arrangement with others, on the basis of prepaid premiums without regard to the frequency or extent of services furnished to an individual member. |
| External Research Organizations | External organizations, including consulting firms, colleges and universities, that buy or use HCFA data for research purposes. |
| Department of Health and Human Services | The Cabinet-level department of the Federal Government of which HCFA is an operating division. |
| Beneficiaries | A person who is eligible for benefits from HCFA-administered programs. |

In addition to understanding the context in which HCFA's mission, vision, goals, and strategic objectives will be carried out, it is important to understand the actual functions that the enterprise must perform to fulfill the requirements of the strategic direction established by the Agency's mission, vision, goals, and strategic objectives. These functions are described in the enterprise-wide Business Function Model (BFM) presented in the next section. The BFM serves as the foundation for identifying HCFA's informational and technical needs, which are identified in Volumes 3, 4, and 5 of the ITA.

2.3 HCFA Business Function Model

The BFM is a hierarchical model that describes HCFA in terms of the essential business activities it performs to carry out its mission and vision and to satisfy its business goals and objectives. These business activities are referred to as essential because they are performed regardless of how the Agency is organized to perform them, and regardless of what technology is used to support them.

The hierarchical model includes an association of the high-level activities to the Agency's strategic objectives, which are categorized in the HCFA Strategic Plan as Customer Service, Quality of Care, and Program Administration. These objectives are also detailed in Section 2.2, HCFA Strategic Business Direction, of this volume.

2.3.1 Definitions

This section provides a graphical and textual description of the HCFA BFM. It first defines the meaning of the major BFM components, i.e., Functional Areas, Functions, and Processes. It then includes several graphical representations of how the Functional Areas, Functions, and Processes are related to one another. Finally, it includes a textual description of each BFM component.

Functional Area (FA)

- A Functional Area is a classification for a logical grouping of related business activities such that it supports or accomplishes an aspect of HCFA's mission and vision.
- A Functional Area is not a HCFA organizational component.
- Examples of HCFA Functional Areas are Program Development, Program Operations Management, and Medicare Financial Management.
- A Functional Area is defined entirely by its parts, which are referred to as Functions.

Function (F)

- A Function is a logical grouping of related business activities such that it further defines the Functional Area in which it belongs.
- Functions define "what" activities HCFA performs, but not "how" these activities are performed.
- Functions will remain relatively stable, although HCFA may change its organizational structure and/or its Processes.
- A Function is not a HCFA organizational component.
- Examples of HCFA Functions are Medicare Beneficiary Enrollment Policy Development, Customer Outreach, and Quality Improvement.
- A Function is defined entirely by its parts, which are referred to as Processes.

Process (P)

- A Process is a specific HCFA business activity that produces a result meaningful to the business of HCFA.
- A Process describes "what" activities are performed by the Agency, while not considering "how" the Agency performs them. Processes are described independent of the HCFA organizational component(s) performing the Process, the techniques used to perform the Process, when the Process is scheduled for execution, and where it is physically performed.
- A Process is "executable" in that it is triggered by some event or "arrival" of information, and its execution is completed when the desired business result is achieved.
- Examples of HCFA Processes are Pay Managed Care Organizations, Determine Quality of Care Indicators for the Peer Review Organization Program, and Guide Medicaid/CHIP Program Integrity Policy for States.

2.3.2 HCFA High-Level Business Function Model

The BFM includes a graphical high-level view of HCFA's Functional Areas and Functions. This view is depicted in Exhibit 2-10, which shows the Functional Areas and Functions and how they relate to one another. The exhibit also identifies the Strategic Objective categories associated with each Functional Area.

EXHIBIT 2-10. HCFA'S HIGH-LEVEL BUSINESS FUNCTION MODEL

Strategic Objective Categories:



= Program Administration



= Quality Of Care



Customer Service

60

FA1: **HCFA Management**

- F1.1: Strategic Planning
- F1.2: Organizational Management
- F1.3: Program Assessment
- Investment Management F1.4:

FA2: **Program Development**



- Partner Relationship Policy Development
- F2.2: Actuarial Services
- F2.3: Medicare Beneficiary Enrollment Policy Development
- F2.4: Medicaid/CHIP Beneficiary Eligibility Policy Development
- F2.5: Payment Policy Development
- Coverage Policy Development F2.6: Program Data and Statistics F2.7:
- Research and Evaluation F2.8:
- **Demonstration Project Management** F2.9:
- F2.10: Legislation Development
- Medicare Claims Appeals, Grievances, and Complaints F2.11:
- Policy Development
- F2.12: Quality of Care/Utilization Review Policy Development
- F2.13: Program Integrity Policy Development
- F2.14: Policy Development for Participation of Providers

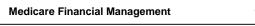
FA3: **Program Operations Management**





- F3.1:
- Medicare Beneficiary Enrollment/Maintenance Medicaid and CHIP Entitlement/Eligibility and Maintenance F3.2:
- F3 3: Provider Enrollment/Maintenance
- Managed Care Organizations Eligibility F3.4:
- F3.5: Medicare Contractor Management F3.6: Peer Review and ESRD Network Contractor Management
- F3.7: Medicare Claims Processing
- Claims Pricing F3.8:
- F3.9: State Health Insurance Oversight
- F3.10: Coordination of Benefits
- F3.11: Medicare Appeals, Grievances, and Complaints Processing

FA4:



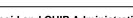
- F4.1: Contractor Administrative Budget & Cost Monitoring
- F4.2: Premium Collection
- F4.3: Benefit Payment Accounting
- Medicare Contractor Banking F4 4· F4 5 Provider Financial Management
- F4.6: Provider Cost Reports
- F4.7: MCO Payment and Fee Collection
- F4.8: **Debt Collection Accounting**

FA5: **Program Integrity Operations**



- F5.1: Post-Payment Review
- F5.2: Utilization Monitoring
- F5.3: Medical Review
- Fraud, Waste, and Abuse F5 4: F5.5
- Medicare Secondary Payer Review
- F5 6: Compliance Monitoring

FA6: **Medicaid and CHIP Administration**





F6.2: Medicaid and CHIP Budget Maintenance

F6.3: State Performance Evaluation F6.4: State Medicaid and CHIP Funding

State Medicaid Program and CHIP Initiatives F6.5:

F6.6: Medicaid Drug Rebate Management

F6.7: System Certification

FA7: **External Communication**



- Congressional Liaison
- F7.2: Media Liaison
- F7.3: Intergovernmental Liaison
- F7.4: Health Care Industry Communications
- Beneficiary Representative Organization Liaison F7.5:
- Employer Group Liaison F7 6
- F7.7: State Liaison

FA8: Administrative Services



- F8.1: Administrative Finance F8 2. Human Resources
- F8 3: Information Distribution Management
- F8.4: Contractor Procurement and Management
- F8.5: **Facilities Management**
- Information Technology Management and Services F8.6:

FA9: **Outreach and Education**



- Policy Change Impact Analysis F9 1:
- F9.2: Health Care Requirements Determination
- F9.3: Public/Beneficiary Awareness and Assistance
- F9.4: Beneficiary Communication F9.5: Customer Outreach



FA10: Health Industry Standards

- Electronic Data Interchange Standards Development F10.1:
- Unique Identifiers Development F10.2:
- F10.3: Standard Forms Development
- F10 4 Health Care Industry Standard Code Development F10.5: Information Technology (IT) Industry Standards



- FA11: Program Quality Quality Protection F11 1:
- F11 2 Quality Improvement

2.3.3 HCFA High-Level Business Processes (Decomposition)

With this version of the BFM, we have begun decomposing the functions performed by HCFA into high-level processes. Our goal is to continue this decomposition by selecting processes based on Agency program priorities and the availability of existing process descriptions.

This version of the BFM, depicted in Exhibit 2-11, includes processes derived from the analysis of the Managed Care business area and the Peer Review Organization business area. Processes resulting from the analysis of the Managed Care business area have been designated with an "(MC)" indicator; those resulting from the analysis of the Peer Review Organization business area have been designated with the "(PRO)" indicator. However, this does not necessarily mean that they are solely related to the Managed Care business area or the Peer Review Organization business area. During the analysis of the respective business areas and the identification of the high-level processes, the appropriate processes were refined to reflect an enterprise-wide view.

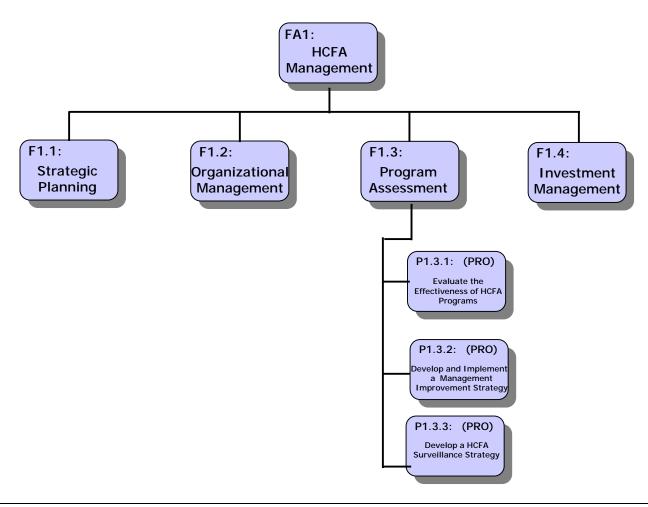
Please note that there will always appear to be discontinuities or gaps in functions containing identified processes. These discontinuities exist because analysis is being done selectively on a *business area* by *business area* basis. Therefore, only the processes for those business areas that have been analyzed are present. Processes for business areas not yet analyzed will not be present and could appear to be omissions.

The BFM depicts only high-level (first level) processes. Processes at more detailed levels are documented by each business area as a result of additional analysis, and following the policies and standards described in the Business Architecture Modeling Policy Framework, Section 2.5.

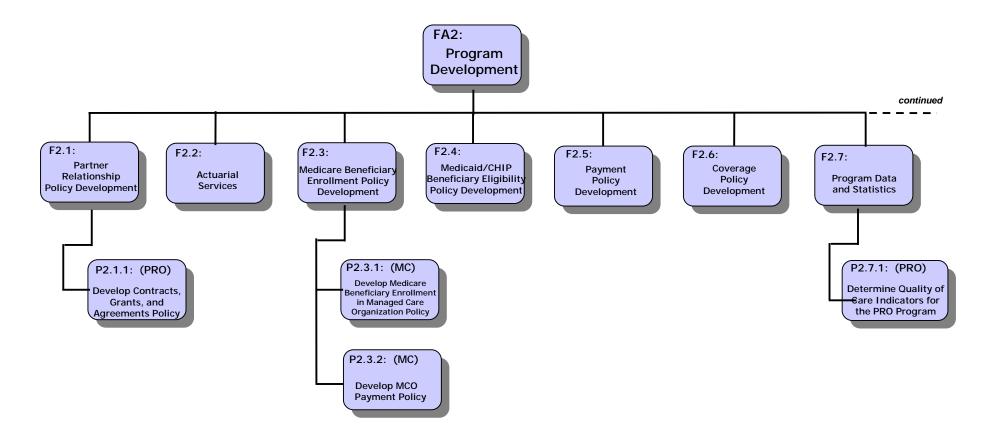
In future iterations of the Business Architecture, the decomposition of the high-level business processes will be placed in an attachment to this volume.

EXHIBIT 2-11. HCFA HIGH-LEVEL BUSINESS PROCESS DECOMPOSITION

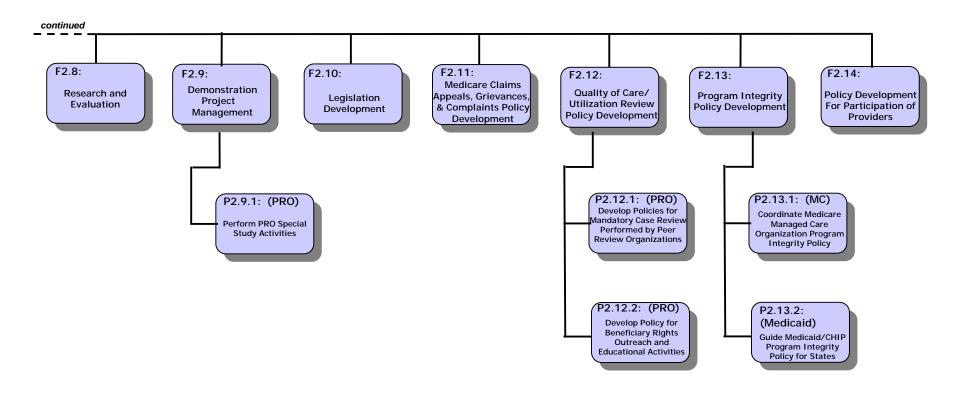
Functional Area 1: HCFA Management



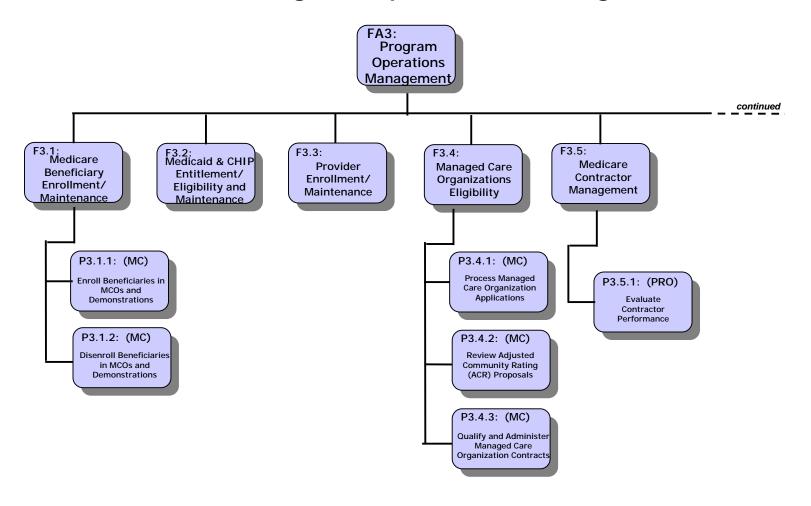
Functional Area 2: Program Development



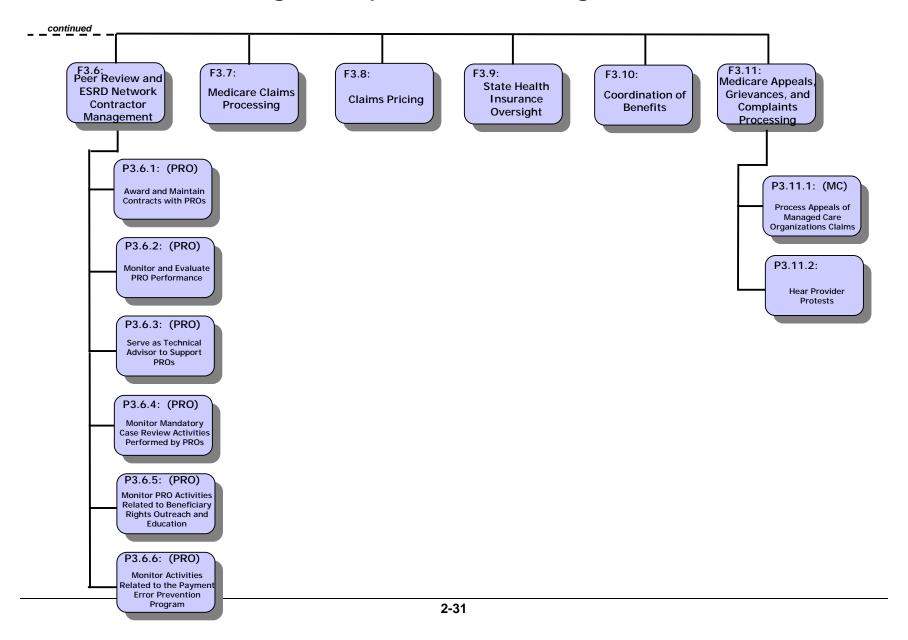
Functional Area 2: Program Development - Continued



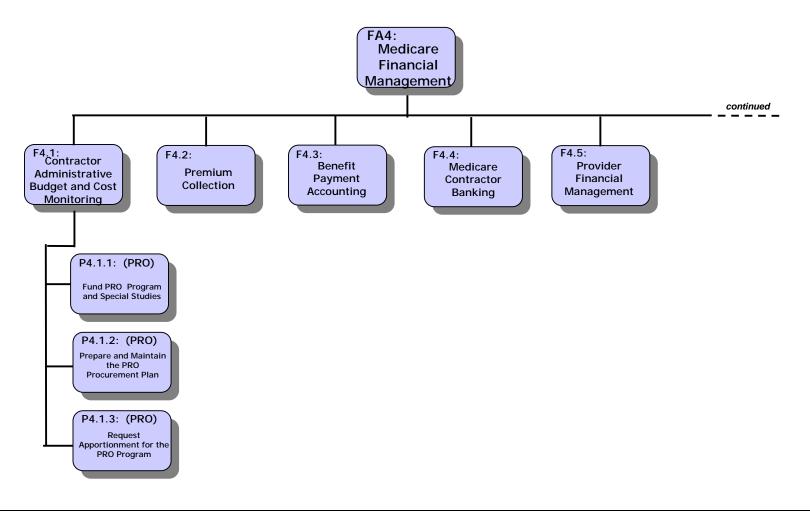
Functional Area 3: Program Operations Management



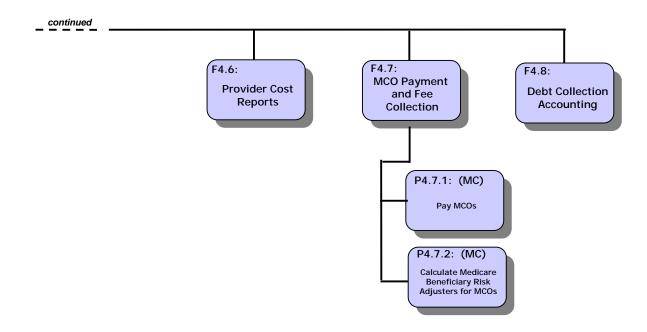
Functional Area 3: Program Operations Management - Continued



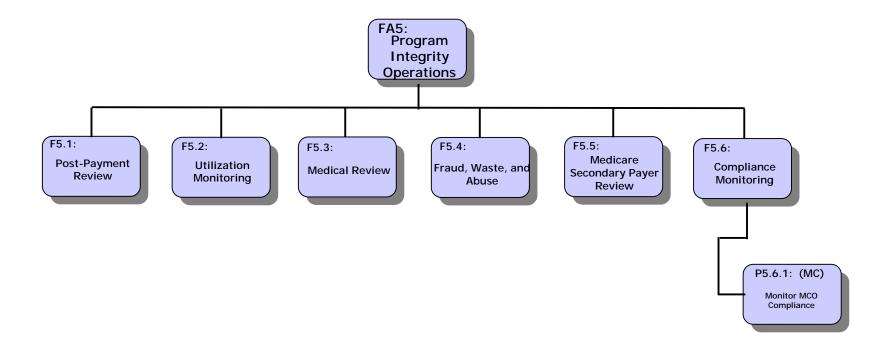
Functional Area 4: Medicare Financial Management



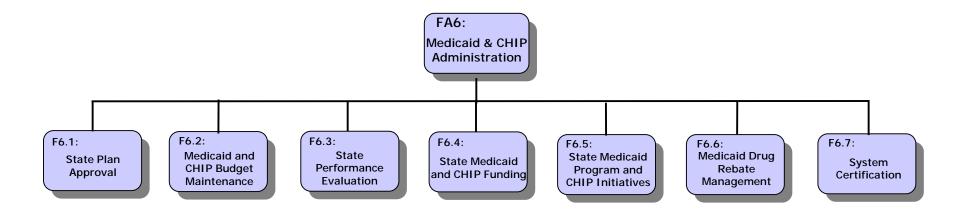
Functional Area 4: Medicare Financial Management - Continued



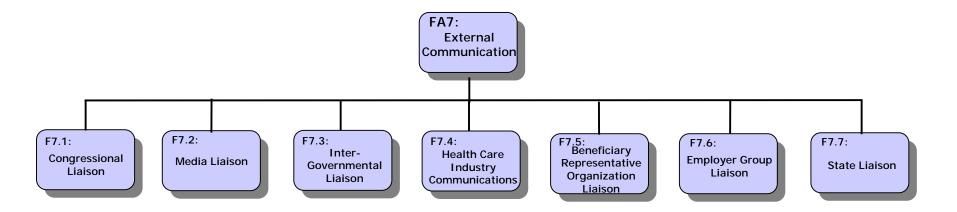
Functional Area 5: Program Integrity Operations



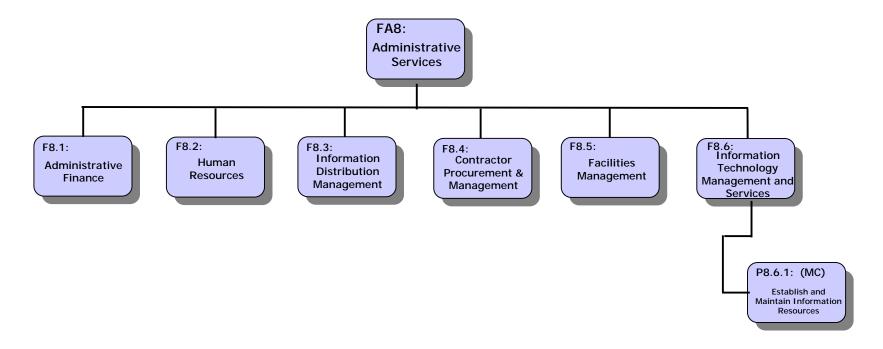
Functional Area 6: Medicaid and CHIP Administration



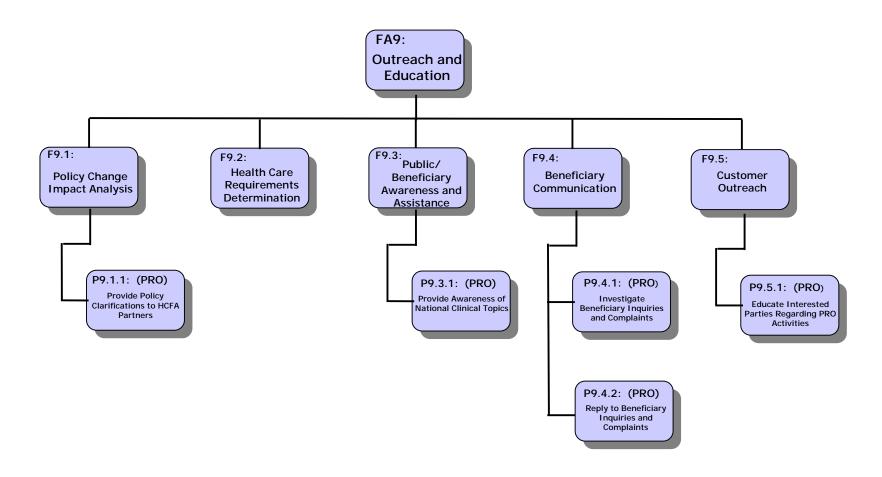
Functional Area 7: External Communication



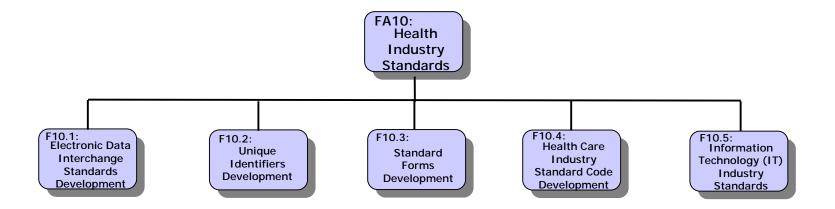
Functional Area 8: Administrative Services



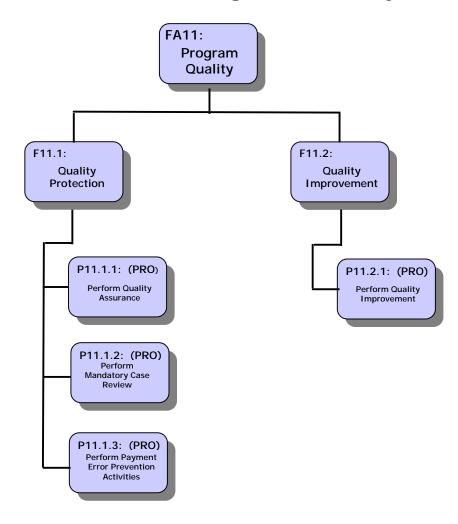
Functional Area 9: Outreach and Education



Functional Area 10: Health Industry Standards



Functional Area 11: Program Quality



2.3.4 HCFA Business Function Model Descriptions

As indicated in the previous section, the BFM includes a decomposition of selected functions into high-level business processes that were chosen based on Agency program priorities and the availability of existing process descriptions.

This version of the BFM includes processes derived from analysis of the Managed Care business area and the Peer Review Organization business area. Managed Care processes are designated with the "(MC)" indicator, and Peer Review Organization processes with the "(PRO)" indicator.

As stated in Section 2.3.3, processes identified as "(MC)" or "(PRO)" are not necessarily solely related to the Managed Care business area or the Peer Review Organization business area. During the analysis of the respective business areas and the identification of the high-level processes, the appropriate processes were refined to reflect an enterprise-wide view.

FA1: HCFA Management

The functions necessary to establish Agency direction, to manage Agency personnel, and to evaluate the overall effectiveness of the Agency's programs.

F1.1: Strategic Planning

The processes necessary to identify, prioritize, schedule, and implement the Agency's missions, goals, and project initiatives

F1.2: Organizational Management

The processes necessary to assign program/project responsibilities, perform employee management, and develop and implement HCFA personnel policies.

F1.3: Program Assessment

The processes necessary to evaluate the effectiveness of HCFA's programs and missions. This includes the oversight of organizations to which HCFA responsibilities and functions have been delegated. It also ensures internal training and that the staff's level of knowledge is sufficient to administer HCFA programs.

P1.3.1: Evaluate the Effectiveness of HCFA Programs (PRO)

Perform the activities required to collect and analyze data and information to determine the extent to which HCFA is achieving the greatest amount of success possible from Agency initiatives (e.g., quality projects and contractor claims processing).

P1.3.2: Develop and Implement a Management Improvement Strategy (PRO)

Perform the activities required, based on the results of the program evaluation, to develop a strategy that will achieve the greatest success in the management of HCFA's initiatives. Implement the strategy.

P1.3.3: Develop a HCFA Surveillance Strategy (PRO)

Perform the activities required to develop a strategy for an integrated approach to surveillance of beneficiary health status.

F1.4: Investment Management

The processes necessary to manage HCFA's investments, such as technology and productivity investments.

FA2: Program Development

The functions necessary to effectively develop policy and monitor the implementation of that policy for HCFA's health care insurance program responsibilities.

F2.1: Partner Relationship Policy Development

The processes necessary to develop policy defining the relationships between HCFA and other entities that participate in HCFA-administered programs.

P2.1.1: Develop Contracts, Grants, and Agreements Policy (PRO)

Perform activities required to formulate policy for developing contracts, grants, and other types of agreements for HCFA to partner with outside entities to perform ongoing activities carrying out HCFA-administered programs. This also includes the policies developed to establish relationships between HCFA's partners and their external partners for purposes of carrying out HCFA-administered programs.

F2.2: Actuarial Services

The processes necessary to develop and use methodologies for macroeconomic analysis of health care financing issues and estimate HCFA program expenditures under current law and under proposed modifications to current law. The setting of premiums and program payment rates is also included.

F2.3: Medicare Beneficiary Enrollment Policy Development

The processes necessary to develop, interpret, evaluate, and monitor program policies pertaining to the conditions under which individuals meet the criteria for enrollment in Medicare program service delivery options.

P2.3.1: Develop Medicare Beneficiary Enrollment in Managed Care Organization (MCO) Policy (MC)

Perform the activities required to develop policy related to enrollment and disensollment of beneficiaries in MCOs.

P2.3.2: Develop MCO Payment Policy (MC)

Perform the activities required to develop policy for the calculation of payments to MCOs and the development of beneficiary-level risk adjusters.

F2.4: Medicaid/CHIP Beneficiary Eligibility Policy Development

The processes necessary to develop, interpret, evaluate, and monitor program policies pertaining to the conditions under which individuals are eligible for Medicaid or State Children's Health Insurance Program (CHIP).

F2.5: Payment Policy Development

The processes necessary to formulate, monitor, and evaluate national policy for payments and payment dispute resolution for health insurance programs that HCFA oversees and administers.

F2.6: Coverage Policy Development

The processes necessary to develop, evaluate, and review national policies and standards concerning the items and services covered under HCFA-administered programs and national policies concerning the resolution of disputes over access to covered items and services.

F2.7: Program Data and Statistics

The processes necessary to plan, direct, and manage the collection and analysis of data and the production of statistics on HCFA-administered programs for internal and external users.

P2.7.1: Determine Quality of Care Indicators for the PRO Program (PRO)

Perform the activities required to identify quality-of-care indicators for clinical areas to be addressed by the PROs. These indicators will also be used as baseline data for evaluating PRO performance.

F2.8: Research and Evaluation

The processes necessary to direct the development and conduct of research and evaluation studies concerning the impact of Federal financing programs on the health care industry, program beneficiaries, and expenditures.

F2.9: Demonstration Project Management

The processes necessary to manage enrollment in and the development, implementation, and monitoring of experiments testing health care delivery and payment alternatives, demonstrations, and special studies.

P2.9.1: Perform PRO Special Study Activities (PRO)

Perform the activities required to review and approve, deny, or suggest changes to PRO proposals submitted to perform a special study, and to oversee the study once awarded. This also includes the development and review of concept papers for a special study proposal developed by HCFA staff and the selection of the appropriate PRO(s) to perform the approved study.

F2.10: Legislation Development

The processes necessary to monitor Federal and State legislation with regard to its effects on HCFA-administered programs. Included in this function are the collection and analysis of data; development of legislative proposals; development of responses to proposed legislation; communication with the legislative and regulatory originators; and formulation of HCFA's regulations and manuals, including any necessary notification and educational activities.

- F2.11: Medicare Claims Appeals, Grievances, and Complaints Policy Development

 The processes necessary to develop, interpret, evaluate, and monitor program
 policies pertaining to the resolution of appeals and complaints resulting from a
 denial of beneficiary access to covered services or of beneficiary payment for
 covered services already received.
- F2.12: Quality of Care/ Utilization Review Policy Development (MC)

The processes necessary to develop policy relative to the quality of care given by health care providers participating in HCFA-administered programs.

P2.12.1: Develop Policies for Mandatory Case Review Performed by Peer Review Organizations (PRO)

Perform the activities required to establish policy related to mandatory case reviews, including those involving beneficiary complaints, referrals, assistance at cataract surgery, Emergency Medical Treatment and Active Labor Act violations, non-coverage notices, medical necessity, 96-hour extended stays, sanction recommendation development, and requests for higher-weighted diagnosis-related groups (DRGs).

P2.12.2: Develop Policy for Beneficiary Rights Outreach and Educational Activities (PRO)

Perform activities required to formulate policy with regard to beneficiary rights outreach and education. This includes participation in local meetings on preventive medicine, distribution of beneficiary rights materials, and other educational activities.

F2.13: Program Integrity Policy Development

The processes necessary to develop policy relative to the detection of fraud, waste, and abuse by providers participating in HCFA-administered programs.

P2.13.1: Coordinate Medicare Managed Care Organization Program Integrity Policy (MC)

Perform the activities required to develop policies that reduce fraud, waste, and abuse associated with health care services provided by managed care organizations.

P2.13.2: Guide Medicaid/CHIP Program Integrity Policy for States (Medicaid)

Perform the activities required to develop policies that guide and assist States in the implementation of Medicaid and CHIP program integrity initiatives. This includes development of State Medicaid Director letters, regulations, proposed legislation, and other policy-related activities, as well as liaison activities for implementing the policies.

F2.14: Policy Development for Participation of Providers

The processes necessary to develop, interpret, and evaluate program policies pertaining to the conditions under which providers (including hospitals, skilled nursing facilities, home health agencies, clinical laboratories, physicians, therapists, and other entities providing health care services to beneficiaries) meet the criteria for participating in HCFA-administered programs.

FA3: Program Operations Management

The functions necessary to manage HCFA programs. This includes determining if individuals, providers, and managed care organizations initially meet, and continue to meet, the requirements for participation in HCFA-administered programs; managing contractors (Medicare, PRO, and ESRD Networks, call center contractors, specialty contractors, and external appeals entities); pricing and processing Medicare claims/encounter data; and handling beneficiary appeals, grievances, and complaints.

F3.1: Medicare Beneficiary Enrollment/Maintenance

The processes necessary to establish and maintain Medicare beneficiary records and to coordinate enrollment in Medicare program options for individuals entitled to Medicare benefits. This function includes receipt and maintenance of

Medicare entitlement and demographic information from the Social Security Administration, Railroad Retirement Board, and Office of Personnel Management, as well as enrollment, disenrollment, and change data for beneficiary elections of appropriate service delivery and payment options.

[Note: At this time, processes relative to MCOs are shown here. Processes relative to Medicare enrollment, in general, will be added in a future model.]

- P3.1.1: Enroll Beneficiaries in MCOs and Demonstrations (MC)

 Perform the activities required to enroll Medicare beneficiaries in managed care organizations. The process includes validating the beneficiary's eligibility to enroll in the managed care organization; annotating our records; generating confirmation and denial reports and notices; and, when appropriate, generating lock-in notices and/or initiating the termination of the beneficiary from another managed care organization.
- P3.1.2: Disenroll Beneficiaries in MCOs and Demonstrations (MC)

 Perform the activities required to terminate enrollment of a Medicare beneficiary in a managed care organization. The process includes validating the beneficiary's eligibility status for disenrollment from the managed care organization; annotating our records; generating a notice to the beneficiary and confirmation/denial reports; and, when appropriate, initiating the process of "rolling over" a beneficiary to another managed care organization.
- F3.2: Medicaid and CHIP Entitlement/Eligibility and Maintenance

 The processes necessary to establish and maintain Medicaid entitlement and
 CHIP eligibility records and to monitor entitlement/eligibility for individuals covered
 under the Medicaid and CHIP programs.

F3.3: Provider Enrollment/Maintenance

The processes necessary to identify, verify, and register physicians, suppliers, non-physician practitioners, and institutional providers for purposes of billing under the Medicare program. This function compiles and maintains information relating to such entities and ensures that applicants and current participants meet the specific statutory, regulatory, and policy requirements. This includes desk review analysis, onsite verification, development of specialty reports, issuance of findings, preparation of determination recommendation, corrective action review, and enforcement.

F3.4: Managed Care Organizations Eligibility

The processes necessary to determine whether organizations initially meet the specific provisions for participation in Federal managed care organizations. This includes organizations that seek Federal qualification and/or Medicare contractual agreements. This results in either the issuance of a Federal qualification approval certificate or a determination of eligibility or ineligibility.

- P3.4.1: Process Managed Care Organization Applications (MC)

 Perform the activities required to review and approve applications and service area expansion applications, including the conducting of site visits. This process also includes determining eligibility or ineligibility and issuing Federal qualification approval certificates.
- P3.4.2: Review Adjusted Community Rating (ACR) Proposals (MC)

 Perform the activities required to review and approve Adjusted Community Rating (ACR) proposals.
- P3.4.3: Qualify and Administer Managed Care Organization Contracts (MC)

 Perform the activities necessary to establish and interpret contract policy, prepare recommendations for contract approval/disapproval, coordinate managed care organization-initiated non-renewal, and prepare recommendations for contract termination.

F3.5: Medicare Contractor Management

The processes necessary to establish contracts and manage Medicare contractor workloads and transitions, develop and communicate contractor requirements, and evaluate contractor performance. This process also includes contractor management of the Medicare fiscal contractors, specialty contractors, call center contractors, and other contractors associated with payment of Medicare claims, as well as managed care organizations.

P3.5.1: Evaluate Contractor Performance (PRO)

Perform the activities required to collect and analyze data on each contractor to determine if the contractor is performing effectively. In the case of PROs, this includes the collection of both cost and clinical measures.

F3.6: Peer Review and ESRD Network Contractor Management

The processes necessary to coordinate, implement, and manage the Peer Review and ESRD Network contractors.

P3.6.1: Award and Maintain Contracts with PROs (PRO)

Perform the activities required to develop a Request for Contract,

analyze a contract proposal, conduct negotiations, track contracting activities, modify existing contracts, and analyze contract modification

proposals for the PRO program.

P3.6.2: Monitor and Evaluate PRO Performance (PRO)

Perform the activities required to monitor compliance with PRO contract requirements, including the tracking of project status for National Quality Improvement Projects (QIPS) and Local QIPS, and providing guidance on concepts for Local QIPS. This also includes developing and executing a strategy for monitoring compliance of PROs relative to conducting mandatory case reviews, and performing beneficiary rights outreach and education. In addition, this process includes the collection of both cost and clinical measures to determine if the PRO is performing effectively.

- P3.6.3: Serve as Technical Advisor to Support PROs (PRO)

 Perform the activities required to support the PROs in their work in accordance with the scope of their contract.
- P3.6.4: Monitor Mandatory Case Review Activities Performed by PROs (PRO)

 Perform the activities required to determine if mandatory case review is being conducted as specified by policy and is resulting in the desired outcome.
- P3.6.5: Monitor PRO Activities Relative to Beneficiary Rights Outreach and Education (PRO)

 Perform the activities required to monitor PRO performance with regard to beneficiary rights outreach and educational activities.
- P3.6.6: Monitor Activities Relative to the Payment Error Prevention Program (PRO)

 Monitor the activities performed by the PROs to reduce the payment error rate. This process also includes reviewing reports submitted by the PROs about the types of interventions and processes they are using in targeting providers for error reduction.
- F3.7: Medicare Claims Processing

The processes necessary to manage, validate, and determine payable amounts for Medicare claims; handle exceptions (non-MR, non-MSP); exchange claims data with insurance trading partners; and maintain claims history information. This process also includes the actual processing of claims, as well as managing encounter data and claims data. [Note: Claims processing is currently performed by Medicare claims processing contractors.]

F3.8: Claims Pricing

The processes necessary to create and maintain required reasonable charge screens, fee schedules, and other pricing determination mechanisms.

F3.9: State Health Insurance Oversight

The processes necessary to oversee State health insurance programs.

F3.10: Coordination of Benefits

The processes necessary to establish relationships with insurance companies for the purpose of exchanging claims information. This includes the negotiation, receipt, and maintenance of Coordination of Benefits Agreements.

F3.11: Medicare Appeals, Grievances, and Complaints Processing

The processes necessary to handle appeals related to enforcement of HCFA decisions about payment of claims, participation in HCFA-administered programs, and other decisions that might have a negative impact on our partners or beneficiaries.

P3.11.1: Process Appeals of Managed Care Organization Claims (MC)

Perform the activities required to collect, maintain, and analyze information, and to make decisions related to adverse managed care organization claims determinations and reconsiderations.

P3.11.2: Hear Provider Protests

Perform the activities required to hear cases related to protests over participation in Agency programs filed by HCFA-administered program providers, including hospitals, skilled-nursing facilities, home health agencies, clinical laboratories, physicians, therapists and other covered entities providing health care services, as well as by those applying to become approved providers.

FA4: Medicare Financial Management

The functions necessary to determine and monitor Medicare contractor budgets, collect premiums and debts, handle Medicare contractor bank accounts, manage provider financial matters and cost reports, and reimburse managed care organizations.

F4.1: Contractor Administrative Budget and Cost Monitoring

The processes necessary to develop contractor/State/quality organization budgets and to administer funds after budget approval. This function includes annual budget development and submission, as well as the ongoing tracking and reporting of expenditures.

P4.1.1: Fund PRO Program and Special Studies (PRO)

Perform the activities required to appropriately fund a PRO by producing a cost estimate, managing fund distribution and expenditures, and monitoring program costs.

P4.1.2: Prepare and Maintain the PRO Procurement Plan (PRO)

Perform the activities required to ensure that PRO expenditures are appropriate and do not exceed available funds.

P4.1.3: Request Apportionment for the PRO Program (PRO)

Perform the activities required to develop a request for funds from MB to operate the PRO Program.

F4.2: Premium Collection

The processes necessary to manage the collection of Hospital Insurance and Supplementary Medical Insurance premiums for Medicare from third parties or directly from beneficiaries who do not receive monthly Social Security benefits.

F4.3: Benefit Payment Accounting

The processes necessary to manage accounts payable and accounts receivable, manage cash, and document payment for the Medicare program.

F4.4: Medicare Contractor Banking

The processes necessary to establish bank accounts, manage accounts, and control funds flowing through those accounts.

F4.5: Provider Financial Management

The processes necessary to analyze financial information to determine periodic interim payments, pass through payments, advance/accelerated payments, and produce provider-specific reports reflecting interim and final payments. This function also includes the processes needed to recover overpayments made to providers.

F4.6: Provider Cost Reports

The processes necessary to receive, process, perform audits of, and resolve cost reports for providers who are reimbursed based on reasonable costs or prospective payment.

F4.7: MCO Payment and Fee Collection (MC)

The processes necessary to certify and monitor Medicare payments and collect user fees.

P4.7.1: Pay MCOs (MC)

Perform the activities required to generate monthly payments to managed care organizations participating in the Medicare program, including the computation of beneficiary-specific rates, the calculation of beneficiary adjustments, and the calculation of user fees. This also includes the calculation of payment for distribution of payments into a beneficiary's medical savings account.

P4.7.2: Calculate Medicare Beneficiary Risk Adjusters for MCOs (MC)

Perform the activities required to calculate the risk adjuster for each Medicare beneficiary enrolled in a managed care organization.

F4.8: Debt Collection Accounting

The processes necessary to manage and recover mistaken/conditional payments to providers, managed care organizations, physicians, and other Medicare providers, including those mistaken/conditional payments resulting from medical review; fraud, waste, and abuse detection; Medicare secondary payer review; provider audits; or other detection methods.

FA5: Program Integrity Operations

The functions necessary to ensure HCFA-administered programs achieve and maintain a high degree of integrity. This includes both pre- and post-payment program integrity assessment procedure development and post-payment program integrity functions.

F5.1: Post-Payment Review

The processes necessary to determine the accuracy and timeliness of Medicare payments to providers and other entities. This includes the review of cost-based, prospective, and alternative payment systems, and the oversight of Part B payments calculated using the reasonable charge methodology.

F5.2: Utilization Monitoring

The processes necessary to administer utilization review of inpatient, post-hospital, outpatient, physician, provider, and ancillary care claims. This function also includes performing quality assurance for claims processing, as well as monitoring encounter data elements from managed care organizations.

F5.3: Medical Review

The processes necessary to ensure that payments are made only for services that are covered by Medicare and are correctly coded. This function includes the review of both claims and encounter data.

F5.4: Fraud, Waste, and Abuse

The processes necessary to provide fraud, waste, and abuse prevention information; respond to internal and external customer complaints of alleged fraud, waste, or abuse; identify and investigate alleged fraudulent, wasteful, or abusive activities; and provide incentives/rewards to those who identify possible fraud, waste, or abuse. Also included in this function are promoting fraud awareness; implementing sanctions; assisting States with Medicaid and CHIP fraud, waste, and abuse prevention; and developing strategies for sharing information between HCFA-administered programs.

F5.5: Medicare Secondary Payer Review

The processes necessary to identify beneficiaries that have coverage primary to Medicare.

F5.6: Compliance Monitoring

The processes necessary to identify, track, and/or enforce procedures and activities aimed at ensuring and improving provider and MCO compliance with program requirements.

P5.6.1: Monitor MCO Compliance (MC)

Perform the activities required to verify that a managed care organization is operating in compliance with HCFA's program requirements. This includes conducting site visits, conducting audits, enforcing sanctions, and implementing corrective-action plans.

FA6: Medicaid and CHIP Administration

The functions necessary to administer the Medicaid program and State Child Health Insurance Program (CHIP).

F6.1: State Plan Approval

The processes necessary to establish the State Medicaid Plan and CHIP Plan approval process and to execute that process.

F6.2: Medicaid and CHIP Budget Maintenance

The processes necessary to monitor State Medicaid and CHIP budgets and to develop Federal Medicaid and CHIP budgets.

F6.3: State Performance Evaluation

The processes necessary to evaluate State Medicaid and CHIP performance.

F6.4: State Medicaid and CHIP Funding

The processes necessary to supply funds to the State Medicaid and CHIP programs.

F6.5: State Medicaid Program and CHIP Initiatives

The processes necessary to provide States with information on the benefits of improving their Medicaid and CHIP programs.

F6.6: Medicaid Drug Rebate Management

The processes necessary to establish drug rebate agreements, determine drug rebate amounts, and monitor utilization of the drug rebate program.

F6.7: System Certification

The processes necessary to review and approve State Medicaid Management Information Systems.

FA7: External Communication

The functions necessary to maintain working relationships with external organizations and individuals. Included are interactions with Congress, the media, the public, State and local governments, other U.S. Government agencies, and academic institutions, health care providers, and the health care industry.

F7.1: Congressional Liaison

The processes necessary to provide information, interpretation, and analysis services regarding Congressional activities related to HCFA-managed programs. Included is the development of responses, background information, and bill reports.

F7.2: Media Liaison

The processes necessary to maintain relationships with the media, including press, radio, television, wire services, individual reporters, editors, publishers, producers, writers, broadcasters, and any private or public sector partners.

F7.3: Intergovernmental Liaison

The processes necessary to provide intergovernmental communication and coordination of issues pertinent to HCFA.

F7.4: Health Care Industry Communications

The processes necessary to provide liaison with medical, dental, and allied health practitioners, institutional providers of health services, representatives of the business and insurance community, and academic institutions responsible for the education of health care professionals.

F7.5: Beneficiary Representative Organization Liaison

The processes necessary to provide liaison with national, State, or local

organizations that counsel, advocate, represent, or educate beneficiaries on HCFA-administered programs.

F7.6: Employer Group Liaison

The processes necessary to provide liaison with companies or corporations with whom HCFA exchanges information to assist in the education of employees and retirees on health insurance plans.

F7.7: State Liaison

The processes necessary to provide the States with communication and coordination of issues pertinent to HCFA.

FA8: Administrative Services

The functions necessary to provide common services in support of HCFA's mission.

F8.1: Administrative Finance

The processes necessary to provide budget and accounting administrative services for HCFA's financial management program. Also included is the payment of contractor and vendor invoices and travel advances/reimbursements to employees.

F8.2: Human Resources

The processes necessary to classify, train, hire, and retire employees. Also included are activities related to the administration of employee benefits, employee incentive programs, labor relations, and EEO programs.

F8.3: Information Distribution Management

The processes necessary to provide publication and disbursement services for documents in both printed and electronic media. This includes the development of graphics and library services.

F8.4: Contractor Procurement and Management

The processes necessary to acquire products and services in accordance with applicable laws, regulations, and policies. This process does not include contracts that are legislatively mandated, such as carrier, intermediary, DMERC, and managed care organization contracts.

F8.5: Facilities Management

The processes necessary to manage physical facilities and deliver facility-related administrative services.

F8.6: Information Technology Management and Services

The processes necessary to provide information technology support required by the Agency in the performance of its mission and objectives. This includes the management of information, data, applications, infrastructure, IT standards, and IT security.

P8.6.1: Establish and Maintain Information Resources (MC)

Perform the activities required to compile and maintain information relating to particular subject areas that result in the construction of databases, data marts, or data warehouses.

FA9: Outreach and Education

The functions necessary for communication between HCFA and its program beneficiaries, recipients, providers, and partners.

F9.1: Policy Change Impact Analysis

The processes necessary to analyze the impact of proposed HCFA policies, regulations, and instructions on beneficiaries, recipients, providers, and partners.

P9.1.1: Provide Policy Clarifications to HCFA Partners (PRO)

Perform the activities required to identify a need for policy clarification and provide the clarification to involved partners (e.g., Medicare contractors, PROs, States).

F9.2: Health Care Requirements Determination

The processes necessary to determine health care requirements through direct contact with the elderly and the needy and to communicate these requirements to HCFA components.

F9.3: Public/Beneficiary Awareness and Assistance

The processes necessary to seek out and provide information to potential eligible beneficiaries and recipients through public-awareness campaigns, counseling, assistance, and outreach programs. This function provides for public awareness of HCFA-administered programs and encourages participation. This includes the development and refinement of written materials and other modes of communication with potential beneficiaries and recipients in order to provide useful, accurate, and comprehensive information to enable potential beneficiaries to make informed health care delivery choices.

P9.3.1: Provide Awareness of National Clinical Topics (PRO)

Perform the activities required to inform Medicare beneficiaries about

best health care practices related to selected national clinical topics that will improve the beneficiary's health status.

F9.4: Beneficiary Communication

The processes necessary to ensure that correct and prompt responses are made to inquiries and complaints received from beneficiaries. This function ensures that corrective action is taken in response to a problem.

- P9.4.1: Investigate Beneficiary Inquiries and Complaints (PRO)

 Perform the activities required to investigate beneficiary complaints received via a hotline, written correspondence, FAX, or some other vehicle, within statutory time constraints.
- P9.4.2: Reply to Beneficiary Inquiries and Complaints (PRO)

 Perform the activities required to reply to beneficiary complaints received via a hotline, written correspondence, FAX, or some other vehicle, within statutory time constraints.

F9.5: Customer Outreach

The processes necessary to educate, inform, and survey beneficiaries, organizations representing beneficiaries, recipients, providers and other partners, and interested parties, etc., concerning programs and their administration. This excludes responses to individual information requests and surveys.

P9.5.1: Educate Interested Parties Regarding PRO Activities (PRO)

Perform the activities required to educate the community about PRO activities such as quality improvement projects, national quality improvement statistics, and other PRO-related topics.

FA10: Health Industry Standards

The functions necessary to work with industry in developing industry-wide standards to ensure that the health care needs of Americans are appropriately considered.

- F10.1: Electronic Data Interchange Standards Development

 The processes necessary to develop and maintain electronic data interchange health care transaction standards with the industry.
- F10.2: Unique Identifiers Development

The processes necessary to develop and maintain industry-wide unique identifiers for beneficiaries, providers, health care payers (e.g., PAYERID), and other entities relative to health care.

F10.3: Standard Forms Development

The processes necessary to develop and maintain standard forms and formats in collaboration with the health care industry.

F10.4: Health Care Industry Standard Code Development

The processes necessary to work with the health care industry in developing diagnosis and medical procedure codes, as well as other codes affecting payment.

F10.5: Information Technology (IT) Industry Standards

The processes necessary to work with the IT industry in developing standards (e.g., IT development tools and commercial/government off-the-shelf software products) to ensure that the needs of HCFA's beneficiaries are met.

FA11: Program Quality

The functions necessary to monitor and improve the quality of health care provided to and the health status of beneficiaries participating in HCFA-administered programs.

F11.1: Quality Protection

The processes necessary to identify, investigate complaints about, disallow for payment, and/or correct health care that falls below standards. This includes processes performed by PROs, State agencies (survey and certification), and ESRD Networks.

P11.1.1: Perform Quality Assurance (PRO)

Perform the activities required to ensure that high-quality care is provided to beneficiaries by MCOs and all health care providers, including identifying and investigating complaints, processing grievances against MCOs and other providers, and performing other quality assurance activities.

P11.1.2: Perform Mandatory Case Review (PRO)

Perform the activities required to review beneficiary cases involving complaints, referrals, assistance at cataract surgery, critical access hospitals, sanctions, higher-weighted DRGs, non-coverage notices, and medical necessity.

P11.1.3: Perform Payment Error Prevention Activities (PRO)

Perform the activities required to reduce payment error rates. This includes analyzing State data, targeting providers with high error rates, and educating providers on ways to improve service.

F11.2: Quality Improvement

The processes necessary to ensure that health care rendered by HCFA-administered programs reflects current clinical and scientific knowledge. This includes processes performed by PROs, State agencies (survey and certification), MCOs, and ESRD Networks.

P11.2.1: Perform Quality Improvement (PRO)

Perform the activities required to conduct both national and local quality improvement projects.

2.4 HCFA Business Organization

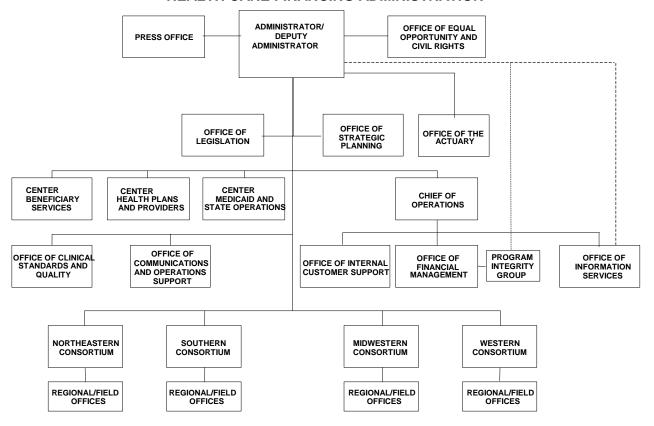
To carry out the functions presented in the BFM, HCFA has structured the organization as depicted in the HCFA Organizational Component Chart shown in Exhibit 2-12. This section describes the HCFA organizational structure and how HCFA's organizational components and various external entities are linked with the Agency's functions.

A more detailed description of the HCFA components can be found on the HCFA Intranet at:

<u>http://hcfanet.hcfa.gov/projects/reorg/reorgcht/orgmain.htm</u> and <u>http://hcfanet.hcfa.gov/projects/reorg/function/func.htm</u>

EXHIBIT 2-12. HCFA ORGANIZATIONAL COMPONENT CHART 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION



⁴ This representation is based on the HCFA Organizational Chart, dated August 2, 1999, contained on the HCFA Intranet.

In order to simplify the understanding of HCFA's organizational structure and the functions performed by the Agency's organizational components, we have categorized the HCFA components and the shaded external entities from the Business Context Diagram (Exhibit 2-8) into logical groupings, depicted in Exhibit 2-13. These are the components and agents that perform needed enterprise functions for HCFA. These logical groupings provide a way of categorizing the commonality of functions and processes performed by these organizations, both the HCFA components and the external entities. The logical grouping will also be used when associating organizations with the functions they perform and the locations where those functions are performed.

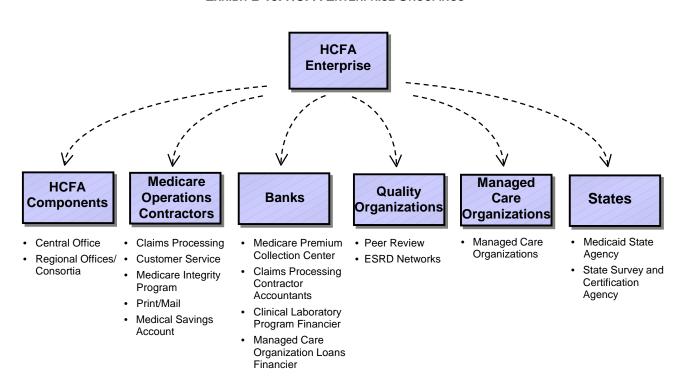


EXHIBIT 2-13. HCFA ENTERPRISE GROUPINGS

2.4.1 Function/Organization Matrix

The Function/Organization Matrix associates specific business functions with the HCFA components and external entities performing those functions. The organizations appearing in the matrix are grouped logically as depicted in Exhibit 2-13.

The HCFA Function/Organization Matrix is shown in Exhibit 2-14. The referenced Functional Areas (FA) and Functions (F) are from the HCFA BFM presented in Section 2.3.

EXHIBIT 2-14. HCFA FUNCTION/ORGANIZATION MATRIX

| Functional Area | I: HCFA Management | 2: Program Development | 3: Program Operations Management | t: Medicare Financial Management | 5: Program Integrity Operations | S: Medicaid and CHIP Admin- istration | 7: External Communica- tion | 3: Administrative Services | 9: Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|--|---------------------------|---|---|--|--|---|------------------------------------|-------------------------------|------------------------------------|------------------------------------|--------------------------|
| Organization | FA1: | FA2: | FA3: | FA4: | FA5: | FA6: | FA7: | FA8: | FA9: | FĀ | FA |
| HCFA Components | | | | | | | | | | | |
| Office of the Administrator | F1.1, F1.2, F1.3, F1.4 | F2.5, F2.6, F2.10 | | | | | F7.1, F7.2, F7.3, F7.4 | | F9.1, F9.4 | | |
| Press Office | F1.1, F1.2, F1.3, F1.4 | F2.1 | | | | | F7.1, F7.2, F7.3, F7.4 | F8.2 | F9.3, F95 | | |
| Office of Equal Opportunity and Civil Rights | F1.1, F1.2, F1.3, F1.4 | F2.1 | | | | | F7.3 | F8.2 | | | |
| Office of Legislation | F1.1, F1.2, F1.3, F1.4 | F2.5, F2.6, F2.10 | | | | | F7.1 | | | | |
| Office of Strategic Planning | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.2, F2.5, F2.6, F2.7, F2.8, F2.9, F2.10 | F3.8 | F4.7 | | | | | F9.1, F9.5 | | |
| Office of the Actuary | F1.1, F1.2, F1.3, F1.4 | F2.2, F2.5, F2.6, F2.7, F2.8, F2.10 | F3.8 | F4.7 | F5.4 | | | | F9.1, F9.3 | | |
| Center for Beneficiary Services | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.3, F2.4, F2.7, F2.8, F2.9, F2.10,F2.11 F2.13 | F3.1, F3.4, F3.5, F3.7, F3.10, F3.11 | F4.1, F4.2, F4.8 | F5.1, F5.2, F5.3, F5.4, F5.5, F5.6 | | F7.1, F7.3, F7.4, F7.5 F7.6, | F8.6 | F9.1, F9.2, F9.3, F9.4, F9.5 | F10.1, F10.2, F10.3 | F11.1, F11.2 |

| Functional Area | . HCFA Management | Program Development | : Program Operations Management | : Medicare Financial Management | : Program Integrity Operations | : Medicaid and CHIP Admin- istration | External Communica- tion | . Administrative Services | : Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|---|---------------------------|---|--|---|--|---|---|--|------------------------------------|---|--------------------------|
| Organization | FA1: | FA2: | FA3: | FA4: | FA5: | FA6: | FA7: | FA8: | FA9: | FA1 | FA1 |
| Center for Health Plans and Providers | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.3, F2.4, F2.5, F2.6, F2.7, F2.8, F2.9, F2.10,F2.12, F2.14 | F3.1, F3.3, F3.4, F3.7 F3.8, F3.11 | F4.6, F4.7, F4.8 | F5.1, F5.2, F5.3, F5.4, F5.5, F5.6 | | F7.1, F7.3, F7.4 | F8.6 | F9.3, F9.5 | F10.1, F10.2, F10.3, F10.4 | |
| Center for Medicaid and State Operations | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.4, F2.5, F2.6, F2.7, F2.8, F2.9,F2.10, F2.12, F2.13 | F3.1, F3.2, F3.3, F3.4, F3.7, F3.9, F3.10 | F4.1 | F5.1, F5.2, F5.3, F5.4, F5.6 | F6.1, F6.2, F6.3, F6.4, F6.5, F6.6, F6.7 | F7.1, F7.2, F7.3, F7.4, F7.7 | F8.1, F8.2, F8.3, F8.4, F8.5, F8.6 | F9.1, F9.2, F9.3,F9.4, F9.5 | F10.1, F10.2, F10.3, F10.4 | F11.1, F11.2 |
| Office of Clinical Standards and Quality | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.7, F2.8, F2.9, F2.10,F2.12, F2.14 | F3.5, F3.6 | F4.1 | F5.2, F5.3 | | F7.4 | F8.4, F8.6 | F9.1, F9.2, F9.3, F9.4, F9.5 | | F11.1, F11.2 |
| Office of Communications and Operations Support | F1.1, F1.2, F1.3, F1.4 | F2.8, F2.9 | | | F5.4 | | F7.1, F7.2, F7.3, F7.4 | | F9.2, F9.3, F9.4, F9.5 | | |
| Office of Internal Customer Support | F1.1, F1.2, F1.3, F1.4 | | | | | | F7.3 | F8.1, F8.2, F8.3, F8.4, F8.5, F8.6 | | F10.5 | |
| Office of Financial Management | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.5, F2.7, F2.8, F2.9, F2.10, F2.12,F2.13 | F3.1, F3.11 | F4.1, F4.2, F4.3, F4.4, F4.5, F4.6, F4.7, F4.8 | F5.1, F5.2, F5.3, F5.4, F5.5, F5.6 | F6.2, F6.4, F6.5 | F7.1, F7.2, F7.3, F7.4 | F8.1, F8.6 | F9.1, F9.3, F9.4, F9.5 | F10.2 | F11.1, F11.2 |
| Office of Information Services | F1.1, F1.2, F1.3, F1.4 | F2.2, F2.3, F2.4, F2.7, F2.8, F2.9, F2.10 | F3.1, F3.4, F3.7, F3.8, F3.10 | F4.2, F4.3, F4.6, F4.7 | F5.2, F5.5 | | F7.1, F7.3, F7.4 | F8.1, F8.2, F8.3, F8.5, F8.6 | F9.1, F9.3, F9.4 | F10.1, F10.2, F10.3, F10.4, F10.5 | |
| Consortia & Regional/Field Offices | F1.1, F1.2, F1.3, F1.4 | F2.1, F2.3, F2.4, F2.5, F2.6, F2.7 | F3.1, F3.3 F3.4, F3.5, F3.6, F3.8, F3.9, F3.10, F3.11 | F4.1, F4.2, F4.5, F4.6, F4.7, F4.8 | F5.1, F5.2, F5.3, F5.4, F5.5, F5.6 | F6.1, F6.2, F6.3, F6.4, F6.5, F6.6, F6.7 | F7.1, F7.2, F7.3, F7.4, F7.5, F7.6, F7.7 | F8.1, F8.2, F8.4, F8.5, F8.6 | F9.1, F9.2, F9.3, F9.4, F9.5 | | F11.1, F11.2 |

| Functional Area | HCFA Management | Program Development | Program Operations Management | Medicare Financial Management | Program Integrity Operations | Medicaid and CHIP Administration | External Communica- tion | Administrative Services | Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|---|--------------------|---------------------|---|--|------------------------------------|----------------------------------|--------------------------------|----------------------------|------------------------|-------------------------------------|--------------------------|
| Organization | FA1: | FA2: | FA3: | FA4: | FA5: | FA6: | FA7: | FA8: | FA9: | FA1 | FA1 |
| Medicare Operations Contractors | | | | | | | | | | | |
| Claims Processing Contractors | | F2.5, F2.6 | F3.3, F3.7, F3.8, F3.10, F3.11 | F4.1, F4.3, F4.4, F4.5, F4.6 | | | F7.2, F7.4, F7.5, F7.6 | F8.6 | F9.1, F9.5 | F10.1, F10.2, F10.3, F10.4 | |
| Customer Service Contractors | | | F3.7 | | | | | | F9.4 | | |
| Medicare Integrity Program Contractors | | | | F4.1 | F5.1, F5.2, F5.3 | | | F8.6 | F9.1 | | |
| Print/Mail Contractors | | | | F4.2 | | | | | | | |
| Medical Savings Account Contractors | | | | F4.7 | | | | | | | |
| Banks | | | | | , | , | | | | | , |
| Medicare Premium Collection Center | | | | F4.2 | | | | | | | |
| Claims Processing Contractor Accountants | | | | F4.4 | | | | | | | |
| Clinical Laboratory Program Financier | | | | F4.4 | | | | | | | |

| Functional Area Organization | FA1: HCFA Management | FA2: Program Development | FA3: Program Operations Management | FA4: Medicare Financial Management | FA5: Program Integrity Operations | FA6: Medicaid and CHIP Admin- istration | FA7: External Communica- tion | FA8: Administrative Services | FA9: Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|--|-------------------------|--------------------------|--|--|---|---|-------------------------------------|---------------------------------|-----------------------------|------------------------------------|--------------------------|
| MCO Loan Financier | | | | F4.4 | | | | | | | |
| | | | | 1 4.4 | | | | | | | |
| Quality Organizations Peer Review | | F2.9, F2.12 | F3.11 | F4.1 | | | F7.2, F7.4, | F8.6 | F9.1, F9.3, | | |
| Organizations | | F2.9, F2.12 | F3.11 | F 4. | | | F7.2, F7.4, F7.5, F7.6 | F6.0 | F9.1, F9.3, F9.4, F9.5 | | F11.1, F11.2 |
| ESRD Networks | | F2.9, F2.12 | F3.11 | F4.1 | | | F7.2, F7.4, F7.5, F7.6 | F8.6 | F9.1, F9.3, F9.4, F9.5 | | F11.1, F11.2 |
| Managed Care Organizations | | | | <u> </u> | | | | | | | |
| Managed Care Organizations | | | F3.1, F3.4, F3.11 | F4.7, F4.8 | F5.6 | | F7.2, F7.4, F7.5 | F8.6 | F9.1,F9.3, F9.4, F9.5 | | F11.1, F11.2 |
| Ctatas | | | | <u> </u> | | | | <u> </u> | | | |
| Medicaid State Agency | | F2.4, F2.13 | | F4.1 | | F6.1, F6.2, F6.3, F6.4, F6.5, F6.6, F6.7 | F7.7 | F8.6 | F9.1, F9.3, F9.4, F9.5 | F10.1 F10.2, F10.3, F10.4 | |
| State Survey and Certification Agency | | | | F4.1 | | | F7.7 | F8.6 | F9.1, F9.3, F9.4, F9.5 | | F11.1, F11.2 |

2.4.2 HCFA Functional Area/Level of Involvement Matrix

The following HCFA Functional Area/Level of Involvement matrices show the scope of involvement for organizations carrying out the enterprise's functions. These matrices allow HCFA to identify the applications and infrastructure required to support the information needs of the enterprise's numerous components and external entities. There are four possible states of organizational involvement with a function: Decision-Maker (DM), Major Involvement (M), Some Involvement (S), or no involvement. Exhibit 2-15 contains a mapping of HCFA organizations to the HCFA BFM functional areas. For more information concerning the mapping of functions to the components and external entities, please refer to Attachment A.

EXHIBIT 2-15. HCFA FUNCTIONAL AREA/LEVEL OF INVOLVEMENT MATRIX

| Functional Area Organization | FA1: HCFA Management | FA2: Program Development | FA3: Program Operations Management | FA4: Medicare Financial Management | FA5: Program Integrity Operations | FA6: Medicaid and CHIP Administration | FA7: External Communication | FA8: Administrative Services | FA9: Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|---|----------------------|--------------------------|------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|-----------------------------|------------------------------|-----------------------------|---------------------------------|-----------------------|
| HCFA Components | | | | | | | | | | | |
| Office of the Administrator | DM | DM | | | | | DM | | М | | |
| Press Office | S | s | | | | | DM | S | М | | П |
| Office of Equal Opportunity and Civil Rights | S | s | | | | | S | М | | | |
| Office of Legislation | S | DM | | | | | DM | | | | |
| Office of Strategic Planning | DM | DM | S | М | | | | | М | | |
| Office of the Actuary | S | DM | S | S | S | | | | М | | |
| Center for Beneficiary Services | М | DM | DM | DM | М | | DM | М | DM | М | S |
| Center for Health Plans and Providers | М | DM | DM | DM | М | | М | S | DM | DM | |
| Center for Medicaid and State Operations | М | DM | DM | М | S | DM | DM | М | DM | М | DM |
| Office of Clinical Standards and Quality | S | DM | DM | М | S | | М | S | М | | DM |
| Office of Communications and Operations Support | S | S | | | S | | DM | | DM | | |
| Office of Internal Customer Support | DM | | | | | | S | DM | | М | |
| Office of Financial Management | DM | DM | М | DM | DM | М | DM | DM | S | М | S |

DM = decision-maker, M = major involvement, and S = some involvement in at least one Function in the Functional Area.

| Functional Area Organization | FA1: HCFA Management | FA2: Program Development | FA3: Program Operations Management | FA4: Medicare Financial Management | FA5: Program Integrity Operations | FA6: Medicaid and CHIP Administration | FA7: External Communication | FA8: Administrative Services | FA9: Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|---|----------------------|--------------------------|------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|-----------------------------|------------------------------|-----------------------------|---------------------------------|-----------------------|
| HCFA Components | | | | | | | | | | | |
| Office of Information Services | DM | DM | DM | М | S | | М | DM | S | DM | |
| Consortia & Regional/Field Offices | М | S | DM | M | М | M | DM | М | DM | | DM |
| Medicare Operations Contractors | | | | | | | | | | | |
| Claims Processing Contractors | | S | DM | DM | | | S | S | DM | М | |
| Customer Service Contractors | | | S | | | | | | S | | |
| Medicare Integrity Program Contractors | | | | М | М | | | S | S | | |
| Print/Mail Contractors | | s | | | | | | | | | |
| Medical Savings Account Contractors | | | | M | | | | | | | |
| Banks | | | | | | | | | | | |
| Medicare Premium Collection Center | | | | M | | | | | | | |
| Claims Processing Contractor Accountants | | | | | | | | | | | |
| Clinical Laboratory Program Financier | | | | M | | | | | | | |
| MCO Loan Financier | | | | | | | | | | | |
| Quality Organizations | | | | | | | | | | | |
| Peer Review Organizations | | s | М | S | | | S | S | DM | | DM |
| ESRD Networks | | s | М | S | | | s | S | DM | | DM |

DM = decision-maker, **M** = major involvement, and **S** = some involvement in at least one Function in the Functional Area.

| Functional Area Organization | FA1: HCFA Management | FA2: Program Development | FA3: Program Operations Management | FA4: Medicare Financial Management | FA5: Program Integrity Operations | FA6: Medicaid and CHIP Administration | FA7: External Communication | FA8: Administrative Services | FA9: Outreach and Education | FA10: Health Industry Standards | FA11: Program Quality |
|-------------------------------------|----------------------|--------------------------|------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|-----------------------------|------------------------------|-----------------------------|---------------------------------|-----------------------|
| Managed Care Organizations | | | - | | | | | | | | |
| Managed Care Organizations | | | DM | DM | М | | S | S | М | | DM |
| States | | | | | | | | | | | |
| Medicaid State Agency | | S | | S | | М | DM | S | М | М | |
| State Survey & Certification Agency | | | | S | | | DM | S | М | | DM |

DM = decision-maker, M = major involvement, and S = some involvement in at least one Function in the Functional Area.

2.4.3 Organization Locations

HCFA's 4,000+ employees are located across the nation and include professionals in health care, statistics, actuary science, information technology, and related fields. HCFA also has many external contacts and interactions. It coordinates with hundreds of contractors; thousands of care providers, quality organizations, and beneficiary and provider associations; and State governments, as well as beneficiaries and their families.

The locations of the organizational components provide a basis for determining needs and designing the allocation and interchange among IT resources throughout the organization.

The HCFA component locations, a description of each location, and a count of full-time employees associated with that component as of August 15, 1999, are provided in Exhibit 2-16.

EXHIBIT 2-16. HCFA COMPONENT LOCATIONS

| Organization | Description | FTE Count | Organizational Location | | | |
|--|--|--|---|--|--|--|
| Office of the Administrator | Agency leadership | 20 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD, and the Hubert H. Humphrey Building in Washington, DC | | | |
| Press Office | Media liaison and press services | 10 | HCFA Headquarters complex at the Hubert H. Humphrey Building in Washington, DC | | | |
| Office of Equal Opportunity and Civil Rights | Equal opportunity and civil rights activities | s 20 HCFA Headquarters of on Security Blvd. in Baltimore, MD | | | | |
| Office of Legislation | Legislative monitoring and development of legislative proposals | 47 | HCFA Headquarters complex at the Hubert H. Humphrey Building in Washington, DC | | | |
| Office of Strategic Planning | Long-term strategic planning | 106 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD, and the Hubert H. Humphrey Building in Washington, DC | | | |
| Office of the Actuary | Actuarial services | 58 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD | | | |
| Center for Beneficiary Services | Agency interaction with beneficiaries, organization representing beneficiaries, care givers, Medicare contractors, and other representatives | 284 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD | | | |
| Center for Health Plans and Providers | Medicare health care purchasing and policy development | 409 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD | | | |
| Center for Medicaid and State Operations | Medicaid operations and policy development | 397 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD | | | |

| Organization | Description | FTE Count | Organizational Location |
|---|---|--------------|--|
| Office of Clinical Standards and Quality | Quality improvement and policy development | 193 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD |
| Office of Communications and Operations Support | Communications, regulation, issuances, and correspondence support | 143 | Hubert H. Humphrey Building Washington, DC |
| Office of Internal Customer Support | Internal operations support, information technology and management services, and some external contracting activities | 365 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD |
| Office of Financial Management | Financial management | 293 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD |
| Office of Information Services | Information technology management and services | 413 | HCFA Headquarters complex on Security Blvd. in Baltimore, MD |
| Boston Regional Office | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations Clinical Standards & Quality | 141 | John F. Kennedy Federal Building on New Chardon St., Boston, MA |
| Northeast Consortium and New York Regional Offices | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations | 147 | Jacob K. Javits Federal Building on Federal Plaza, New York, NY |
| Philadelphia Regional Office | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations | 142 | Public Ledger Building on Independence Mall West, Philadelphia, PA |
| Southern Consortium and Atlanta Regional Office | Beneficiary Services Health Plans & Providers Financial Management Program Initiatives Medicaid & State Operations | 196 | Atlanta Federal Center on Forsyth St. SW, Atlanta, GA |

| Organization | Description | FTE Count | Organizational Location |
|--|---|--------------|--|
| Dallas Regional Office | Beneficiary Services Health Plans & Providers Financial Management Program Initiatives Medicaid & State Operations Clinical Standards & Quality | 165 | Dallas Office on Young Street, Dallas, TX |
| Chicago Regional Office | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations | 225 | Chicago Federal Office Building on Michigan Ave., Chicago, IL |
| Midwestern Consortium and Kansas City Regional Office | Beneficiary Services Health Plans & Providers Medicaid & State Operations Clinical Standards & Quality | 138 | Richard Bolling Federal Building on East 12 th St., Kansas City, MO |
| Western Consortium and Denver Regional Office | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations | 107 | Colorado State Bank Building on Broadway, Denver, CO |
| San Francisco Regional Office | Beneficiary Services Financial Management Medicaid & State Operations Health Plan and Providers | 164 | San Francisco Office on Hawthorne St., San Francisco, CA |
| Seattle Regional Office | Beneficiary Services Health Plans & Providers Financial Management Medicaid & State Operations Clinical Standards & Quality | 116 | Seattle Office at Blanchard Plaza on Sixth Ave., Seattle, WA |

Exhibit 2-17, on the following page, uses the organizational groupings identified in Exhibit 2-13 to provide an overview of the organizations contained in each group, and their locations.

EXHIBIT 2-17. LOCATIONS FOR HCFA ENTERPRISE GROUPINGS - 10/1/99

| Organization Type | Number of Organizations | Location of Organizations |
|--|--|---|
| | | |
| HCFA Components | | D 100 |
| Central Office Components | 14 | Baltimore, MD Washington, DC |
| Regional Offices/Consortia | 10 Regions 4 of which are Consortia (shown by *) | Boston, MA; New York, NY*; Philadelphia, PA; Atlanta, GA*; Dallas, TX; Kansas City, MO*; Chicago, IL; Denver, CO*; San Francisco, CA; Seattle, WA |
| Medicare Operations Contractors | | |
| Claims Processing Contractors | | |
| Intermediaries (Medicare Part A Contractors) | 33 | Located throughout the USA |
| Regional Home Health Intermediaries | 5 (Subset of the 33 intermediaries) | South Portland, ME; Columbia, SC; Milwaukee, WI; Des Moines, IA; Van Nuys, CA |
| Carriers (Medicare Part B Contractors) | 22 | Located throughout the USA |
| DME Regional Carriers | 4 (Subset of the 22 carriers) | Hartford, CT; Indianapolis, IN; Columbus, SC; Nashville, TN |
| CWF Host Contractors | 7 (5 are also carriers) | Portland, OR; Owings Mills, MD; Los Angeles, CA; Birmingham, AL; Jacksonville, FL; New York, NY; Dallas, TX |

| Organization Type | Number of Organizations | Location of Organizations |
|--|--|--|
| Medicare Operations Contractors (continued) | | |
| Standard System Maintainers | 7 (1 is also a carrier and 2 are intermediaries) | Little Rock, AR; Jacksonville, FL; Towson, MD; Hartford, CT; Plano, TX; Tampa, FL; Baltimore, MD |
| Customer Service Contractors | | |
| Call Centers | 2 | Dallas, TX; Hunt Valley, MD |
| Nationwide Customer Call Center (1-800-638-6833) | 2 to be consolidated to one, 12/1/99 | La Crosse, WI; Davenport, IA to be relocated after 12/1/99 at Waterloo, IA and Indianapolis, IN |
| 1-800 Help Desks | 160 | Located throughout USA , run by claims processing contractors |
| The Medicare Center | 1 | Philadelphia, PA |
| Medicare Integrity Program Contractors | | |
| Program Safeguard Contractor (PSC) | 12 | Rockville, MD; Birmingham, AL; Falls Church, VA; Reston, VA; Alexandria, VA; Syracuse, NY; Salt Lake City, UT; Vienna, VA; Columbia, SC; Milwaukee, WI San Francisco, CA; Plano, TX |
| Statistical Analysis Contractor | Planned, but <=12 | To be determined, but subset of PSC locations |

| Organization Type | Number of Organizations | Location of Organizations |
|--|-------------------------|--|
| Medicare Operations Contractors (continued | | |
| Coordination of Benefits Contractor | 1 | To be determined in November 1999 |
| Print/Mail Contractor | 1 | Baltimore, MD |
| Medical Savings Account Contractors | 2 | Baltimore, MD; Santa Clare, CA |
| Banks | | |
| Medicare Premium Collection Center | 1 | Pittsburgh, PA |
| Claims Processing Contractor Accountants | | |
| Clinical Laboratory Program Financier * | 1 | Atlanta, GA |
| MCO Loan Financier * * There are 2 separate accounts at NATIONSBANK in Atlanta, GA. | 1 | Atlanta, GA |
| Quality Organizations | | |
| Peer Review Organizations | 53 | Each State, Washington DC, and Puerto Rico (American Samoa and Guam are included with Hawaii) |
| ESRD Networks | 18 | CT, NY, NJ, PA, VA,NC,FL,MS, IN,IL,MN,KS,OK,TX,CO, WA, N. CA, S. CA |

| Organization Type | Number of Organizations | Location of Organizations |
|---------------------------------------|-------------------------|---|
| Managed Care Organizations | | |
| Managed Care Organizations | 400 (approximately) | Located in many cities throughout the U.S. |
| States | | |
| State Survey and Certification Agency | 52 | Each State; DC; PR & VI served by same office; and AS, GU, N. Mar. Is. served by HI |
| Medicaid State Agency | 52 | Each State; DC; PR & VI served by same office; and AS, GU, N. Mar. Is. served by HI |

Attachment B provides more detailed descriptive and physical location information related to the HCFA external entities that are shaded in the Business Context Diagram (Exhibit 2-8).

2.5 Business Architecture Modeling Policy Framework

The Business Architecture is a knowledge base of the Agency's business. Policies, standards, and guidelines need to be available so that the integrity of this knowledge base is maintained. This section provides a policy framework for the ongoing and consistent development and refinement of the Business Architecture. Like the other components of the Business Architecture, policy is defined over time and will be included in the Business Architecture as required. This framework provides guidance that is to be followed by all HCFA components when modeling business processes.

The following sections describe the purpose, objectives, and components of HCFA's Business Architecture Modeling Policy Framework.

2.5.1 Purpose

The purpose of the Business Architecture Modeling Policy Framework is to identify HCFA IT policy areas relative to the development, maintenance, and management of the Business Architecture.

Development of the HCFA Business Architecture is an ongoing activity. We will continue to expand and refine the contents of the Business Architecture to address the more detailed processes performed by HCFA and to address changes in the Agency's business. New systems development projects and ongoing maintenance projects are a major source of significant additions to and transformations within the Business Architecture; however, architecture development will continue for as long as the Business Architecture exists, for our business is ever-changing.

Maintenance is required to retain the integrity and viability of the Business Architecture. The Business Architecture must be an accurate, timely, and reliable representation of the Agency's business, and maintenance activities must be conducted to address changes that may be required to resolve inconsistencies, inaccuracies, or inadequacies between the HCFA business environment and the Business Architecture.

Management of the Business Architecture is necessary in order to maximize the usability, reusability, and sharing of Business Architecture content and business process models within Agency business areas, and between systems development projects. It provides an orderly and structured approach to model sharing, merging, and conflict resolution. Management activities include not only coordinating the use of multiple models across concurrent systems development projects, but also addressing any inconsistencies, inaccuracies, and inadequacies in the modeling objects resulting from these concurrent projects.

Development, maintenance, and management policies articulate guidelines regarding the high-level components of the functional areas, functions, and processes described in the Business Function Model. These policies also speak to the detailed business processes, which will be included as future systems development projects for the further delineation of Agency business processes.

2.5.2 Objectives

The objectives of the Business Architecture Modeling Policy Framework are to:

- Support the development of HCFA enterprise-based applications that are consistent with the Agency's strategic direction and priorities;
- Ensure the ability to share and reuse functions and processes across HCFA enterprise-based automated applications;
- Ensure the integrity of the Business Architecture;
- Ensure consistent development and maintenance of the Business Architecture, i.e., the Business Function Model and the Volume 2 document;
- Ensure flexibility in the Business Architecture to allow for rapid and agile response to changes in the business and health care environments; and
- Ensure that the components of the Business Architecture are usable by the business community for making administrative and operational decisions.

2.5.3 Policy Framework

The following sections identify and describe the components of HCFA's Business Architecture Modeling Policy Framework

2.5.3.1 Model Management

The purpose of Model Management policy is to provide guidelines regarding the ongoing development and management of the architectural objects in the Business Architecture. These policies are organized according to business objects, their graphical representation, and the use of modeling tools to capture and maintain information about the architectural objects.

2.5.3.1.1 Business Objects

The purpose of Business Object policy is to provide guidelines regarding the creation, maintenance, and management of the architectural objects and their properties in the Business Architecture and the Business Function Model. Examples of "business objects" are functional areas, functions, processes, and the external organizations doing business with the Agency. Examples of "object properties" are function and process names, their definitions, and the HCFA organizational component responsible for the function or process.

The objectives of Business Object policy are to:

- Ensure the integrity and viability not only of each business object and its properties, but also of the overall Business Architecture:
- Maximize the sharing and reusability of business objects within the HCFA business community and between concurrent systems development projects;
- Ensure quick resolution of object inconsistencies and conflicts; and
- Ensure that business object controls exist to support Model Management activities, such as object versioning and object sharing.

2.5.3.1.2 Model Representation

The purpose of Model Representation policy is to provide guidelines regarding the graphical depiction of the various architectural objects in the Business Architecture and the Business Function Model. The representation may be text-based, diagrammatic (graphical), or a combination of both. An example of text-based representation is the business driver discussion in Section 2.2.3 of this volume. Examples of diagrammatic representations are the Business Context Diagram and the High-Level Business Function Model in Sections 2.2.4 and 2.3.2, respectively. Examples of combined text and diagrammatic representations are the various Organization, Level of Involvement, and Location matrices located throughout Section 2.4, HCFA Business Organization.

The objectives of Model Representation policy are to:

- Develop consistency in the use of graphical techniques within the Business Architecture:
- Provide for graphical representations that facilitate understanding of the Agency's business strategy and direction;
- Provide for graphical representations that facilitate a common understanding of the Agency's business activities, as well as communication between the business community and OIS project team members;
- Identify mandatory graphical representations; and
- Identify preferred and optional graphical representations.

2.5.3.1.3 Modeling Tool Policy

The purpose of Modeling Tool policy is to provide guidelines regarding the use of software productivity aids designed for capturing, maintaining, and producing graphical representations of the business objects in the Business Architecture and the Business Function Model. Modeling tools are software-based enablers that provide support for many of the policies within the Business Architecture Modeling Policy Framework. More specifically, policies related to business objects, model representation, and repository management are advanced by the use of modeling tool policies.

The objectives of Modeling Tool policy are to:

- Ensure that the use of modeling tools facilitates the capture, maintenance, and dissemination of the business information in the Business Architecture;
- Ensure that the use of modeling tools supports the policy objectives and policies for business objects, model representation, and repository management;
- Where possible, support of policy objectives and policies for Business Architecture roles and responsibilities, systems development life cycle (SDLC) process integration, and ITA Management and Governance process integration;
- Ensure that the use of multiple tools for example, a formal modeling software tool
 used in conjunction with a Microsoft Office product involves tools that are mutually
 supportive in capturing and maintaining business information; and
- Provide tool usage guidelines both for the Agency's business community members and for systems development project team members.

2.5.3.2 Business Object Repository Management

The purpose of Business Object Repository Management policy is to provide guidelines for the development, maintenance, and management of the physical media on which HCFA's business objects are actually stored. These physical media include not only electronic computer files, databases, and Internet-based facilities, but also traditional paper-based documents and storage.

The objectives of Business Object Repository Management policy are to:

- Ensure that HCFA business objects are secured and retrievable;
- Ensure that HCFA business objects are recoverable from improper changes, unauthorized changes and access, or other operational failures;
- Ensure that repository controls exist to support model management activities, such as model versioning and model sharing; and
- Ensure that controls such as cross-repository integrity and consistency exist for the use of mixed-media repositories.

2.5.3.3 Business Architecture Roles and Responsibilities

The purpose of Business Architecture Roles and Responsibilities policy is to provide guidelines regarding the functions required to develop and manage the Business Architecture and to identify the components responsible for performing these functions.

A role is a logical aggregation of activities to be carried out in support of the Business Architecture. It is defined in terms of task responsibilities, scope of responsibilities (task boundaries), scope of authority (degree of control within scope of responsibilities), and required expertise. A role does not represent a HCFA job title, position, or a specific Agency employee or Agency department. For ease in understanding this definition, the following example is provided:

The role of Model Manager could consist of task responsibilities to ensure the proper sharing of business objects. The manager's scope of responsibilities could include model sharing at the enterprise-level, but not at the project level. The scope of authority could include full autonomy to maintain model integrity during versioning and sharing. Required expertise could include knowledge of the business objects within the Business Function Model and their accompanying descriptions, as well as competency with the Business Architecture modeling tool.

A role can be carried out by one person or by many persons. One person can carry out more than one role. A role is the basis for personnel assignments. For example, an employee may be assigned the role of Repository Manager, and that same employee and another employee may both be assigned the role of Model Managers.

The objectives of Business Architecture Roles and Responsibilities policy are to:

- Identify roles and responsibilities to support the policy framework identified to date, i.e., Model Management, Repository Management, Systems Development Life Cycle Process Integration and ITA Management and Governance Process Integration;
- Ensure consistent definition of roles in terms of task responsibilities, scope of responsibilities, scope of authority, and required expertise:
- Outline the major duties of each role (the outline is not intended to be a step-by-step procedure for carrying out the role);
- Modify or refine roles to support ongoing Business Architecture development and management requirements; and
- Assign components responsible for major roles.

2.5.3.4 Systems Development Life Cycle Process Integration

The purpose of Systems Development Life Cycle Process Integration policy is to provide guidelines for the consistent and correct use of business objects during the development of systems at HCFA. Business objects represent knowledge about the business of the Agency. In order to facilitate the building of automated computer applications that support the Agency's business direction and priorities, the business objects must drive and propel systems development activities.

The primary challenge of systems development integration is coordination among multiple, concurrently executing projects, each of which is in a different stage of the systems development life cycle. Using the business objects in the Business Architecture, project coordination includes defining project scope, synchronizing interproject priorities, participating in quality reviews, and resolving interproject conflicts. The same coordination challenges exist with projects using the

cyclical systems development life cycle technique.

Process integration also includes the consistent and timely updating of the Business Architecture upon the completion of each individual project and the deployment into the production environment of the project results or end product. Consistent and thorough documentation of the business objects must be maintained and incorporated into the Business Architecture.

The objectives of Systems Development Life Cycle Process Integration policy are to:

- Ensure that systems development projects implement systems that are consistent with the HCFA Strategic Plan;
- Ensure that systems development projects implement systems that are consistent with the major business processes being carried out at HCFA;
- Ensure that systems development projects begin with the analysis and further decomposition of the BFM and business functions and processes;
- Ensure that at the conclusion of systems development projects, automated processes are consistent with the process descriptions in the BFM; and
- Ensure that conflicts between development projects regarding interpretation and/or the use of business objects are reconciled.

2.5.3.5 ITA Management and Governance Process Integration

The purpose of ITA Management and Governance Process Integration policy is to provide guidelines to support HCFA's governance approach in developing and maintaining the overall Information Technology Architecture. These guidelines support the integration of Business Architecture concepts, policies, and standards into the overall Management and Governance processes, as described in Volume 7.

These guidelines ensure that consideration of HCFA's mission, business direction, priorities, and supporting processes is included in the overall Management & Governance processes. The specific processes include the IT Investment Review Process, the ITA Policy and Standards Approval Process, and the ITA "Evergreening" Process.

The objectives of Management and Governance Process Integration policy are to:

 Ensure support of the Executive Council's investment decision-making activities, such as funding projects, reviewing technical designs as they relate to supporting HCFA business direction and the implementation of major business processes, and evaluating HCFA enterprise-wide migration investments;

- Ensure support of the IT Council's authority for coordinating, identifying, recommending, and approving HCFA enterprise-wide ITA designs, policies, and standards; and
- Ensure support of other HCFA entities, such as the Financial Management and Investment Board (FMIB), the Medicare Contractor Change Control Board (MCCB), the DHHS Information Technology Architecture Group (ITAG), and the Federal Agency Information Architecture Working Group (FAIAWG).

2.6 Conclusion

Development of the Business Architecture serves as a basis for engaging the cooperation of organizations throughout the HCFA enterprise in developing the ITA. Such cooperation is essential to the ITA's success.

The Business Architecture provides the knowledge base from which the other ITA components draw. The BFM, the major element of the Business Architecture, includes descriptions of functional areas and functions, as well as processes for selected business areas. It also includes diagrams showing the relationships between these Business Architecture objects. Since the development of the Business Architecture is ongoing, additions and refinements to the BFM will continue as we acquire more knowledge and information about the Agency's business activities. Better-defined functions and processes in the BFM will require changes to the matrices relating the HCFA organization components to the functions and processes they perform. In turn, as the functions and processes are better defined, the usefulness of the BFM will increase with regard to its ability to support strategic, operational, performance, and financial planning; program development; and the alignment of IT initiatives and investments.

In addition, the BFM provides the foundation for the ongoing development and refinement of the Information Architecture, the Application Architecture, the Infrastructure Architecture, and the Security Architecture. This multidimensional ITA bridges the gap between business direction and business needs and the use of information technology. It enables HCFA to be more responsive to the ever-changing HCFA business drivers and their influence on the Agency's Strategic Plan goals and objectives, and on subsequent policy and program direction.

The development of the Business Architecture depends upon input from the business community. If you have any comments or suggestions regarding this volume, please complete the feedback form provided in Section 2.7 and return it to the HCFA ITA Staff in accordance with the instructions contained on the form.

2.7 Feedback Form

A key indicator of the success of the ITA is feedback from the readers of this document. It is important that the ITA be responsive to the needs and objectives of those who are responsible for selecting technologies and deploying systems throughout HCFA. Your responses to this feedback form will allow HCFA staff to determine if this important mission of the ITA is being achieved. Please take a moment to complete the form and return it to the address indicated.

| Do you feel this document is of value to you? Comments: | Yes No |
|---|-----------------------------|
| Are there any topics of discussion that you feel should be added of Comments: | or changed? Yes No |
| Please provide any other comments that you feel will improve the | usability of this document: |
| Please describe your job function: | |
| Please provide your name, mailing address, and E-mail address: | |

Thank you for taking the time to provide your feedback on the HCFA ITA. Your comments and ideas are appreciated. Please send your completed form to the following address:

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